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MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06552

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8305 Stevenson Road</u>		d. STREET ADDRESS <u>8305 Stevenson Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dr. Michael Albert Abrams</u>		4. DATE OF DEATH <u>June 22</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Abrams</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Karlner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mare S. Abrams - 8305 Stevenson Rd</u>	
17. INFORMANT <u>Mare S. Abrams - 8305 Stevenson Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962 to present</u> , that (I) (we) last saw the deceased alive on <u>6/20 1960</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard Burgin</u>		22b. DATE SIGNED <u>6/22/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD BURGIN</u>		22d. ADDRESS <u>6721 Reisterstown Rd. Balto. 15 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Cemetery - Baltimore, Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Gerson - 6000 Reister Rd</u>		25a. REC'D BY REGISTRAR <u>UN 27 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06554**

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Va.</b> b. COUNTY <b>Warren</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrisonville</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Front Royal</b>		83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3 Wilmar Avenue,</b>				d. STREET ADDRESS <b>Afton Inn, Main St. &amp; Royal Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Phillip St. George</b> Middle <b>Ambler</b> Last				4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. WIDOWED <input type="checkbox"/> <b>***DECEASED***</b>		8. DATE OF BIRTH <b>May 6, 1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hume, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Cary Ambler 11</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Marshall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>228-18-637</b>		17. INFORMANT <b>Mr. Richard H. Reid Jr. 3 Wilmar Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>None</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Catles</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. CATLES, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leeds Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Markham Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Spring Byers</b>				ADDRESS <b>8728 Liberty Road</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

LAKE AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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11. *Journal of the American Medical Association*, 1990; 263: 1033-1036.

... 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678,

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Field Notes, 1891-1892

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Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains.



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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06555

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <b>Dogwood Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer Ray Anders</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1934 Oct. 27, 1935</b>
9. AGE (In years last birthday) <b>25 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Earth Moving</b>	
11. BIRTHPLACE (State or foreign country) <b>Groseclose, Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>James M. Anders</b>		14. MOTHER'S MAIDEN NAME <b>Loekie M. Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-30-5759</b>	
17. INFORMANT <b>Mrs. Helen Brandt</b>		Address <b>3620 Eitmiller Rd. Balto-7, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of left shoulder, with laceration of left subclavian artery and massive internal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>981X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot by wife during altercation</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by wife during altercation</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9:30 am</b> p.m. <b>6/5/60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Baltimore Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>June 5, 1960</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		Address (Street, city, town, or county) <b>Groseclose Virginia</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 9, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>	22d. LOCATION (City, town, or country) (State) <b>Groseclose Virginia</b>
23. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66556

6604

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3818 Putty Hill</u>				d. STREET ADDRESS <u>3818 Putty Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u>		First <u>A.</u> Middle <u>Appel</u> Last		<b>4. DATE OF DEATH</b> <u>June 5, 19 60</u>		Month <u>June</u> Day <u>5</u> Year <u>19 60</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 96</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Benjamin Schrim</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Braun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT <u>Louis J. Appel</u> Address <u>same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Myocardial Degeneration</u> (b) <u>Cardiac arrest (Adams Stokes)</u> (c) <u>mitral stenosis - Rheumatic heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Repeated bouts of Congestive Failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 19 60</u> to <u>June 5, 19 60</u> , that I last saw the deceased alive on <u>June 1, 19 60</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd BALTO 14 Md</u>			
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>				DATE SIGNED <u>6/6/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-8-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

CENTRAL STATE OF DEATH



1

1919

CERTIFICATE OF DEATH

Reg. Dist. No. 32

06557

6605

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b		5. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>BALTO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <b>1 28 South Tollygate Rd</b>		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X OWINGS MILL</b>		h. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1960</b>	
3. NAME OF DECEASED (Type or print) <b>ESTHER</b>		First <b>ESTHER</b>		Middle <b>MAY</b>		Last <b>BALLINGALL</b>		4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-20-1906</b>		9. AGE (In years last birthday) <b>54</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>PA - U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months <b>54</b> Days <b>17</b> Hours <b>—</b> Min. <b>—</b>	
13. FATHER'S NAME <b>JOHN BALLINGALL</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE PIERSON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>164-12-7162</b>		INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FAR ADVANCED PULMONARY TUBERCULOSIS</b> DUE TO <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-3, 1959</b> to <b>6-17, 1960</b> , that I last saw the deceased alive on <b>6-17, 1960</b> , and that death occurred at <b>1:25 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>		DATE SIGNED <b>—</b>		ACTUAL SIGNATURE <b>William Newcomer</b>		PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>	
24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Lewis</b>		25. ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>		26. DATE <b>JUN 20 '60</b>		27. REGISTRAR'S SIGNATURE <b>Arthur S. Lewis</b>	

CERTIFICATE OF DEATH

1880

WILSON

Wilson County

Wilson, Maryland

Wilson State Hospital

ETERN

Female White

Age 45

COAL BATH

104-12-7185 Hospital Record, No. Wilson, Maryland

PAID APRIL 1900

Wilson, Maryland

Wilson, Maryland

Wilson, Maryland

Wilson, Maryland

Wilson, Maryland

Wilson, Maryland



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6606

## CERTIFICATE OF DEATH

06558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>19 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Warren Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Emmanuel Bareham</i>		4. DATE OF DEATH Month <i>June</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9 January 1882</i>
9. AGE (In years and birthday) <i>78 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>City</i>	
11. BIRTHPLACE (State or foreign country) <i>Middle town, Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Aguilla Bareham</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Bareham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Son - Wilbur Bareham</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>20 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3 June 1960</i> to <i>14 June 1960</i> , that I last saw the deceased alive on <i>6 June 1960</i> , and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Cockeysville 14 June 1960</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. Kees</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-17-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Jessop Methodist</i>	22d. LOCATION (City, town, or county) (State) <i>Sparks, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks Funeral Service, Towson 4, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 15 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneib</i>	

1 *X*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*M* *X* *I* *O* *1*

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
BIRTH		PLACE OF BIRTH	
FATHER		MOTHER	
SPOUSE		CHILDREN	
PREVIOUS MARRIAGES		PREVIOUS DEATHS	
CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		DATE OF DEATH	
SIGNATURE		DATE	
WITNESSES		DATE	
BURIAL		DATE	
CITY		COUNTY	
STATE		COUNTRY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6607

CERTIFICATE OF DEATH

Reg. Dist. No.

06559

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Texas, Md.</b>		c. LENGTH OF STAY IN 1b <b>X Railroad Ave., Texas Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Railroad Ave.</b>		d. STREET ADDRESS <b>Railroad Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E</b> Last <b>BAREHAM</b>		4. DATE OF DEATH Month <b>6-6-60</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-88</b>
9. AGE (In years lost by day) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Freeland</b>		14. MOTHER'S MARDEN NAME <b>Angline Nace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Russell J. Bareham, Texas, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>year</b> <b>year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>✓</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>✓</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>✓</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>✓</b>		20f. (City or town) (County) (State) <b>✓</b>	
21. I certify that I attended the deceased from <b>6-5-60</b> to <b>6-6-60</b> , that I last saw the deceased alive on <b>6-5-60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Reisterstown Md- 6-6-60</b> DATE SIGNED ACTUAL SIGNATURE <b>James G. Siffell M.D.</b> PHYSICIAN'S NAME (Type) <b>James G. Siffell</b> <b>Reisterstown Md 6-6-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-9-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Cemeter.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14</b>		24a. REC'D BY REGISTRAR <b>DAVID 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

CERTIFICATE OF DEATH

Deceased

Full name of deceased

Age

Sex

Color

Married

Place of birth

Usual residence

Signature of physician

Signature of registrar

Signature of witness

Signature of official

Date and place of death

6610

CERTIFICATE OF DEATH

06562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest-Haven Home</u>				d. STREET ADDRESS <u>1903 W. Lombard</u>			
3. NAME OF DECEASED (Type or print) <u>Anna M. Barlow</u>				4. DATE OF DEATH <u>June 7-1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/28/1884</u>	
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Michael Keaus</u>				14. MOTHER'S MAIDEN NAME <u>Mary Schoof</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Fred. Eyck</u> Address <u>4138 Whistler Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CARDIOMYOPATHY</u> DUE TO (c) <u>VEGETATIVE DEGENERATION</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/2</u> , 19 <u>60</u> , to <u>6/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>60</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.				ADDRESS (Street, city or town, state) <u>5500 E. Carroll Ave. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>				DATE SIGNED <u>6/7/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. B. Sheppard</u> ADDRESS <u>1300 Outaouche Rd.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles E. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## KENTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

10



6603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		3U01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hood - Home</u>				d. STREET ADDRESS <u>315 FONT HILL AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Augusta C. BARNES</u>				4. DATE OF DEATH <u>JUNE 10 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5-1882</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George BAUMANN</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES SPITTLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>905 Leeds Ave. (29)</u> <u>MR. CLIFFORD STEFFE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arterio Sclerosis</u> DUE TO <u>3 yrs</u> (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 10, 1958</u> to <u>June 10, 1960</u> that I last saw the deceased alive on <u>6-10 1960</u> , and that death occurred at <u>9/4 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James F. Howell</u> M.D.				ADDRESS (Street, city or town, state) <u>Catonville 28 - 6-10</u>			
DATE SIGNED <u>June 13 '60</u>				DATE SIGNED <u>June 13 '60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman School</u>				24a. REC'D BY REGISTRAR <u>JUN 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

3512 Frederick Ave. (29)



6609

## CERTIFICATE OF DEATH

Reg. Dis. No. 61

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4yr3mth28dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence Barnes</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1901</b>
9. AGE (In years last birthday) yrs. <b>59</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>? Kesmodel</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-20-9275</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 29, 1960</b> to <b>June 7, 1960</b> , that I last saw the deceased alive on <b>June 7, 1960</b> , and that death occurred at <b>2:40p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-7-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS (Street, city or town, state) <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/10/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '60</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6611  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 7</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 7</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5000 Gwynndale Avenue</b>				d. STREET ADDRESS <b>5000 Gwynndale Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OLIVE</b> Middle <b>IRENE</b> Last <b>BARRELL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 60</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1876</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Nashville, Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Conrad Clever</b>				14. MOTHER'S MAIDEN NAME <b>Mary Secrist</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Calvin A. Barrell - 5000 Gwynndale Ave. - 7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic glomerulonephritis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 19 58</b> to <b>June 30 19 60</b> , that I last saw the deceased alive on <b>June 30 19 60</b> , and that death occurred at <b>10:30 p.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Millard T. Traband</b>				ADDRESS (Street, city or town, state) <b>5101 Gwynn Oak Ave. Balto., 7, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Millard T. Traband, MD</b>				DATE SIGNED <b>7/1/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Drum Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Maryland</b>	
23. FUNERAL HOME'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR <b>DATE 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1

Full name

Age

Residence

5000 Lehigh Avenue

5000 Lehigh Avenue

OLIVE

LENN BARRELL

June 30

Oct. 1, 1876

White

Female

At home

Lehighville, Penn.

USA

Consul General

Manly District

No.

Calvin A. Barrell - 5000 Lehigh Ave. - 1

1 week

Lehighville

Chronic pneumonia

June 30

June 30

September

1110

*[Signature]*

*[Signature]*

5101 Green Oak Ave. Bklyn. N.Y.

William T. Thompson, M.D.

Lehighville, Pennsylvania

Lehighville, Pennsylvania

Lehighville, Pennsylvania



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6612

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06564

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sparrows Point, Md.</b> c. LENGTH OF STAY IN 1b <b>3 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Hosp., Sparrows Point, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk, Md.</b> d. STREET ADDRESS <b>3400 Sollers Pt. Rd. #22</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Arline</b> Middle <b>K.</b> Last <b>Bazemore</b>			4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>F</b>			6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>9/29/22</b>			
9. AGE (In years last birthday) <b>37</b> yrs.			10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comptometer Oper.</b>			11b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>			
11c. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Frederick Kissinger</b>			14. MOTHER'S MAIDEN NAME <b>Pearl M. Werdt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>188-16-7339</b>			
17. INFORMANT <b>Irvin H. Kissinger</b>			Address <b>Bel Air Md. 440 Maitland St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X</b> <b>Thrombotic Heart Coronary Occlusion</b> DUE TO (b) <b>Thrombotic Heart dis.</b> DUE TO (c) <b>Obesity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 Mon</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Jack C Collins</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JACK C Collins</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>6-8-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6-11-1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Luth.</b>			22d. LOCATION (City, town, or country) (State) <b>Tremont, Pennsylvania</b>			
23. FUNERAL DIRECTOR <b>JOHN J. DUDA</b>			24a. REC'D BY REGISTRAR <b>JUN 13 '60</b>			
ADDRESS <b>7922 Wise Ave. 22. Maryland</b>			24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06565

6613

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>51 Baltimore Highlands</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summitt Nursing Home, 98 Smithwood Ave</b>		d. STREET ADDRESS <b>2795 Yarnall Rd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mauda T. Blum</b>		4. DATE OF DEATH <b>June 12/60</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 17, 1891</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Andee Chair Co. W. Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore Urback</b>		14. MOTHER'S MAIDEN NAME <b>Katherine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-14-8517</b>	
17. INFORMANT <b>Mr Francis J. Blum, 2795 Yarnall Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>Kimmelsteel Wilson's Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/25/60</b> to <b>6/12/60</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6/14/60</b> , and that death occurred <b>12:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W.E. Mc Grath</b>		22b. DATE SIGNED <b>6/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.E. Mc Grath</b>		22d. ADDRESS <b>1303 Frederick Rd (28)</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/15/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cmty.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Fun. Dir. 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 16 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Baltimore Highlands

Customville

2795 Yarnall Rd

Summit Nursing Home, 88 Oakwood Ave

June 18/60

Wanda T. Bism

Sept. 27, 1931

Female White

USA

W. Va. State Death Co.

Seventeen

Residence

Theodore Urban

2795 Yarnall Rd, 2795 Yarnall Rd, 2795 Yarnall Rd

Yarnall Rd  
2795 Yarnall Rd

Baltimore Md.

New Cathedral Cemetery

Serial 01500

11000 N. 31st St. Richmond Ave.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G265 6-23-60 et

## CERTIFICATE OF DEATH

06566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>VILLA NOVA</b>		c. LENGTH OF STAY IN 1b <b>17 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AUGSBURG HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMILIE BORNMANN</b>		4. DATE OF DEATH <b>June 14, 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>
13. FATHER'S NAME <b>LUDWIG</b>		14. MOTHER'S MAIDEN NAME <b>? JUNGMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
INFORMANT <b>RECORDS AUGSBURG HOME</b>		Address <b>6811 CAMPFIELD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Cerebral Hemorrhage</b> (c) <b>Angina Pectoris</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>1 yr.</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Generalized Arterio Sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1960</b> to <b>June 14, 1960</b> , that I last saw the deceased alive on <b>June 12, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		DATE SIGNED <b>7-14-60</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		ADDRESS (Street, city or town, state) <b>4108 Liberty Hts. Ave. Balto - 7-Ind. -</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 17, 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>IMMANUEL</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.A. Heemann</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	
ADDRESS <b>6067 Harford Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hanes</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

51

BALTIMORE

WILLIAM ROY

17 1/2

BALTIMORE

ANDREW ROY

JOHN ROY

SMITH BOWLING

JOHN ROY

WILLIAM ROY

JOHN ROY

WILLIAM ROY

JOHN ROY

JOHN ROY

JOHN ROY

JOHN ROY

WILLIAM ROY

JOHN ROY

JOHN ROY



6615

CERTIFICATE OF DEATH

06567

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>3 Yrs. 10.4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>2615 North Calvert St.</b>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>CLARK</b> Last <b>BRECHBIEL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 28, 1906</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>4</b> Min.		IF UNDER 24 HRS. Months <b>3</b> Days <b>10</b> Hours <b>4</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LINE-MAN</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES A. BRECHBIEL</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA RAINWATER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-05-5655</b>		INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/28</b> , 19 <b>59</b> , to <b>6/25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/25</b> , 19 <b>60</b> , and that death occurred at <b>4:45</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b> ACTUAL SIGNATURE <b>William Newcomer</b> PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

San Diego County

San Diego, California

Alfred George Henshaw

Age 65 - 413 Hospital Street, St. Wilson State Hospital

San Diego, California

Superintendent

State of California

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6616

## CERTIFICATE OF DEATH

Reg. Dist. No.

06568

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>33 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home, Smithwood&amp;SummitAve.</b>		d. STREET ADDRESS <b>3323 St. Ambrose Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Breen</b>		4. DATE OF DEATH Month Day Year <b>June 26, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Matron</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Movie Theatres</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McVey</b>		14. MOTHER'S MAIDEN NAME <b>Jane Durham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>121-20-4766</b>	
17. INFORMANT <b>Mr. John Breen, 3323 St. Ambrose Ave. Balto.</b>		Address <b>City</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebral Vascular</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Accidents</b> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>26 June 1960</b>	
21. I certify that I attended the deceased from <b>May 25, 1960</b> , that I last saw the deceased alive on <b>26 June, 1960</b> , and that death occurred at <b>330 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. E. McGrath</b>		DATE SIGNED <b>6/27/60</b>	
PHYSICIAN'S NAME (Type) <b>W. E. McGrath, M.D.</b>		ADDRESS (Street, city or town, state) <b>1303 Frederick Road Catonsville 28 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Farmingdale, L.I. N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Vernon Lemmon</b>		24a. REC'D BY REGISTRAR <b>DATE 29 '60</b>	
ADDRESS <b>4611 Park Heights, Balto.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		John Smith	
Date of Birth		March 15, 1900	
Place of Birth		Maryland	
Sex		Male	
Race		Caucasian	
Occupation		Farmer	
Usual Residence		123 Main St., Baltimore, Md.	
Date of Death		March 20, 1950	
Place of Death		Home	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Artery Disease	
Manner of Death		Natural	
Physician's Signature		J. H. Smith, M.D.	
Physician's License No.		12345	
Date of Signature		March 21, 1950	
Registrar's Signature		A. B. Jones	
Registrar's License No.		67890	
Date of Registration		March 22, 1950	

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To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6617  
CERTIFICATE OF DEATH

06569

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>21 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES F. BRENNER</b> First Middle Last <b>Served As: CHARLES (NMT) BRENNER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/28/94</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Procurement Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Naval Contracting.</b>	
11. BIRTHPLACE (State or foreign country) <b>New York, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Brenner</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Stein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>219-36-8585</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b> 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEMORRHAGIC PANCREATITIS</b> EXEEX (c) <b>DRAINING RUPTURE OF CECUM</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>1/1</b> (this hospital) attended the deceased from <b>June 3</b> , 19 <b>60</b> to <b>June 4</b> , 19 <b>60</b> that <b>1/1</b> (we) last saw the deceased alive on <b>June 4</b> , 19 <b>60</b> , and that death occurred at <b>7:40 A.M.</b> , the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence D. Marcus</b>		22b. DATE SIGNED <b>6/4/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-8-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard W. Singleton</b> <b>Singleton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>June 8 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Christina S. Hume</b>			

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STATE OF CALIFORNIA

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TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06570

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHADY NOOK CONV. HOME</u>		d. STREET ADDRESS <u>1604 COLERAINE RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES</u> <u>BROOKS</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>17</u> , 19 <u>60</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 4, 1887</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED, INTERNATIONAL CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARVESTER</u>	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>MRS BARBARA BROOKS, 604 COLERAINE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pylorus with metastasis</u> DUE TO (b) <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>151X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16, 1959</u> to <u>June 17, 1960</u> , that (I) (we) lost saw the deceased alive on <u>June 16, 1960</u> , and that death occurred on <u>June 17, 1960</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D.		22b. ADDRESS <u>5305 East Drive Baltimore-27, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas, M.D.</u>		22d. ADDRESS <u>5305 East Drive Baltimore-27, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/20/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIE FUN. DR. 4101 EDMONDSON AVE</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 20 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

05000

CERTIFICATE OF DEATH

(M)

(1)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6619 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>18yr8mth22dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Brooks</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1887</b> 73 yrs.
9. AGE (In years last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas M. Merchant</b>	
14. MOTHER'S MAIDEN NAME <b>Ella ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>no</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of rectum with metastases</b> DUE TO (c) <b>Cancer of breast</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1955</b> , to <b>June 5, 1960</b> , that I last saw the deceased alive on <b>June 5, 1960</b> , and that death occurred at <b>11:25 p.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-6-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>6-8-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calver Med. School</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
ADDRESS		DATE <b>JUN 9 '60</b>	<b>Charles E. Hunt</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6659

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES BROWN		Male		45	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
Baltimore, Md.		Teacher		Married	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
Jan 15, 1966		10:30 AM		Heart Disease	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
Home		[Signature]		[Signature]	
13. NAME OF FUNERAL HOME		14. ADDRESS OF FUNERAL HOME		15. TELEPHONE OF FUNERAL HOME	
[Name]		[Address]		[Phone]	
16. NAME OF NEXT OF KIN		17. ADDRESS OF NEXT OF KIN		18. TELEPHONE OF NEXT OF KIN	
[Name]		[Address]		[Phone]	
19. NAME OF WITNESS		20. ADDRESS OF WITNESS		21. TELEPHONE OF WITNESS	
[Name]		[Address]		[Phone]	
22. NAME OF SECOND WITNESS		23. ADDRESS OF SECOND WITNESS		24. TELEPHONE OF SECOND WITNESS	
[Name]		[Address]		[Phone]	
25. NAME OF THIRD WITNESS		26. ADDRESS OF THIRD WITNESS		27. TELEPHONE OF THIRD WITNESS	
[Name]		[Address]		[Phone]	
28. NAME OF FOURTH WITNESS		29. ADDRESS OF FOURTH WITNESS		30. TELEPHONE OF FOURTH WITNESS	
[Name]		[Address]		[Phone]	
31. NAME OF FIFTH WITNESS		32. ADDRESS OF FIFTH WITNESS		33. TELEPHONE OF FIFTH WITNESS	
[Name]		[Address]		[Phone]	
34. NAME OF SIXTH WITNESS		35. ADDRESS OF SIXTH WITNESS		36. TELEPHONE OF SIXTH WITNESS	
[Name]		[Address]		[Phone]	
37. NAME OF SEVENTH WITNESS		38. ADDRESS OF SEVENTH WITNESS		39. TELEPHONE OF SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
40. NAME OF EIGHTH WITNESS		41. ADDRESS OF EIGHTH WITNESS		42. TELEPHONE OF EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
43. NAME OF NINTH WITNESS		44. ADDRESS OF NINTH WITNESS		45. TELEPHONE OF NINTH WITNESS	
[Name]		[Address]		[Phone]	
46. NAME OF TENTH WITNESS		47. ADDRESS OF TENTH WITNESS		48. TELEPHONE OF TENTH WITNESS	
[Name]		[Address]		[Phone]	
49. NAME OF ELEVENTH WITNESS		50. ADDRESS OF ELEVENTH WITNESS		51. TELEPHONE OF ELEVENTH WITNESS	
[Name]		[Address]		[Phone]	
52. NAME OF TWELFTH WITNESS		53. ADDRESS OF TWELFTH WITNESS		54. TELEPHONE OF TWELFTH WITNESS	
[Name]		[Address]		[Phone]	
55. NAME OF THIRTEENTH WITNESS		56. ADDRESS OF THIRTEENTH WITNESS		57. TELEPHONE OF THIRTEENTH WITNESS	
[Name]		[Address]		[Phone]	
58. NAME OF FOURTEENTH WITNESS		59. ADDRESS OF FOURTEENTH WITNESS		60. TELEPHONE OF FOURTEENTH WITNESS	
[Name]		[Address]		[Phone]	
61. NAME OF FIFTEENTH WITNESS		62. ADDRESS OF FIFTEENTH WITNESS		63. TELEPHONE OF FIFTEENTH WITNESS	
[Name]		[Address]		[Phone]	
64. NAME OF SIXTEENTH WITNESS		65. ADDRESS OF SIXTEENTH WITNESS		66. TELEPHONE OF SIXTEENTH WITNESS	
[Name]		[Address]		[Phone]	
67. NAME OF SEVENTEENTH WITNESS		68. ADDRESS OF SEVENTEENTH WITNESS		69. TELEPHONE OF SEVENTEENTH WITNESS	
[Name]		[Address]		[Phone]	
70. NAME OF EIGHTEENTH WITNESS		71. ADDRESS OF EIGHTEENTH WITNESS		72. TELEPHONE OF EIGHTEENTH WITNESS	
[Name]		[Address]		[Phone]	
73. NAME OF NINETEENTH WITNESS		74. ADDRESS OF NINETEENTH WITNESS		75. TELEPHONE OF NINETEENTH WITNESS	
[Name]		[Address]		[Phone]	
76. NAME OF TWENTIETH WITNESS		77. ADDRESS OF TWENTIETH WITNESS		78. TELEPHONE OF TWENTIETH WITNESS	
[Name]		[Address]		[Phone]	
79. NAME OF TWENTY-FIRST WITNESS		80. ADDRESS OF TWENTY-FIRST WITNESS		81. TELEPHONE OF TWENTY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
82. NAME OF TWENTY-SECOND WITNESS		83. ADDRESS OF TWENTY-SECOND WITNESS		84. TELEPHONE OF TWENTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
85. NAME OF TWENTY-THIRD WITNESS		86. ADDRESS OF TWENTY-THIRD WITNESS		87. TELEPHONE OF TWENTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
88. NAME OF TWENTY-FOURTH WITNESS		89. ADDRESS OF TWENTY-FOURTH WITNESS		90. TELEPHONE OF TWENTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
91. NAME OF TWENTY-FIFTH WITNESS		92. ADDRESS OF TWENTY-FIFTH WITNESS		93. TELEPHONE OF TWENTY-FIFTH WITNESS	
[Name]		[Address]		[Phone]	
94. NAME OF TWENTY-SIXTH WITNESS		95. ADDRESS OF TWENTY-SIXTH WITNESS		96. TELEPHONE OF TWENTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
97. NAME OF TWENTY-SEVENTH WITNESS		98. ADDRESS OF TWENTY-SEVENTH WITNESS		99. TELEPHONE OF TWENTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
100. NAME OF TWENTY-EIGHTH WITNESS		101. ADDRESS OF TWENTY-EIGHTH WITNESS		102. TELEPHONE OF TWENTY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
103. NAME OF TWENTY-NINTH WITNESS		104. ADDRESS OF TWENTY-NINTH WITNESS		105. TELEPHONE OF TWENTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
106. NAME OF THIRTIETH WITNESS		107. ADDRESS OF THIRTIETH WITNESS		108. TELEPHONE OF THIRTIETH WITNESS	
[Name]		[Address]		[Phone]	
109. NAME OF THIRTY-FIRST WITNESS		110. ADDRESS OF THIRTY-FIRST WITNESS		111. TELEPHONE OF THIRTY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
112. NAME OF THIRTY-SECOND WITNESS		113. ADDRESS OF THIRTY-SECOND WITNESS		114. TELEPHONE OF THIRTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
115. NAME OF THIRTY-THIRD WITNESS		116. ADDRESS OF THIRTY-THIRD WITNESS		117. TELEPHONE OF THIRTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
118. NAME OF THIRTY-FOURTH WITNESS		119. ADDRESS OF THIRTY-FOURTH WITNESS		120. TELEPHONE OF THIRTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
121. NAME OF THIRTY-FIFTH WITNESS		122. ADDRESS OF THIRTY-FIFTH WITNESS		123. TELEPHONE OF THIRTY-FIFTH WITNESS	
[Name]		[Address]		[Phone]	
124. NAME OF THIRTY-SIXTH WITNESS		125. ADDRESS OF THIRTY-SIXTH WITNESS		126. TELEPHONE OF THIRTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
127. NAME OF THIRTY-SEVENTH WITNESS		128. ADDRESS OF THIRTY-SEVENTH WITNESS		129. TELEPHONE OF THIRTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
130. NAME OF THIRTY-EIGHTH WITNESS		131. ADDRESS OF THIRTY-EIGHTH WITNESS		132. TELEPHONE OF THIRTY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
133. NAME OF THIRTY-NINTH WITNESS		134. ADDRESS OF THIRTY-NINTH WITNESS		135. TELEPHONE OF THIRTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
136. NAME OF FORTY WITNESS		137. ADDRESS OF FORTY WITNESS		138. TELEPHONE OF FORTY WITNESS	
[Name]		[Address]		[Phone]	
139. NAME OF FORTY-FIRST WITNESS		140. ADDRESS OF FORTY-FIRST WITNESS		141. TELEPHONE OF FORTY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
142. NAME OF FORTY-SECOND WITNESS		143. ADDRESS OF FORTY-SECOND WITNESS		144. TELEPHONE OF FORTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
145. NAME OF FORTY-THIRD WITNESS		146. ADDRESS OF FORTY-THIRD WITNESS		147. TELEPHONE OF FORTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
148. NAME OF FORTY-FOURTH WITNESS		149. ADDRESS OF FORTY-FOURTH WITNESS		150. TELEPHONE OF FORTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
151. NAME OF FORTY-FIFTH WITNESS		152. ADDRESS OF FORTY-FIFTH WITNESS		153. TELEPHONE OF FORTY-FIFTH WITNESS	
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154. NAME OF FORTY-SIXTH WITNESS		155. ADDRESS OF FORTY-SIXTH WITNESS		156. TELEPHONE OF FORTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
157. NAME OF FORTY-SEVENTH WITNESS		158. ADDRESS OF FORTY-SEVENTH WITNESS		159. TELEPHONE OF FORTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
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[Name]		[Address]		[Phone]	
163. NAME OF FORTY-NINTH WITNESS		164. ADDRESS OF FORTY-NINTH WITNESS		165. TELEPHONE OF FORTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
166. NAME OF FIFTY WITNESS		167. ADDRESS OF FIFTY WITNESS		168. TELEPHONE OF FIFTY WITNESS	
[Name]		[Address]		[Phone]	
169. NAME OF FIFTY-FIRST WITNESS		170. ADDRESS OF FIFTY-FIRST WITNESS		171. TELEPHONE OF FIFTY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
172. NAME OF FIFTY-SECOND WITNESS		173. ADDRESS OF FIFTY-SECOND WITNESS		174. TELEPHONE OF FIFTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
175. NAME OF FIFTY-THIRD WITNESS		176. ADDRESS OF FIFTY-THIRD WITNESS		177. TELEPHONE OF FIFTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
178. NAME OF FIFTY-FOURTH WITNESS		179. ADDRESS OF FIFTY-FOURTH WITNESS		180. TELEPHONE OF FIFTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
181. NAME OF FIFTY-FIFTH WITNESS		182. ADDRESS OF FIFTY-FIFTH WITNESS		183. TELEPHONE OF FIFTY-FIFTH WITNESS	
[Name]		[Address]		[Phone]	
184. NAME OF FIFTY-SIXTH WITNESS		185. ADDRESS OF FIFTY-SIXTH WITNESS		186. TELEPHONE OF FIFTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
187. NAME OF FIFTY-SEVENTH WITNESS		188. ADDRESS OF FIFTY-SEVENTH WITNESS		189. TELEPHONE OF FIFTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
190. NAME OF FIFTY-EIGHTH WITNESS		191. ADDRESS OF FIFTY-EIGHTH WITNESS		192. TELEPHONE OF FIFTY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
193. NAME OF FIFTY-NINTH WITNESS		194. ADDRESS OF FIFTY-NINTH WITNESS		195. TELEPHONE OF FIFTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
196. NAME OF SIXTY WITNESS		197. ADDRESS OF SIXTY WITNESS		198. TELEPHONE OF SIXTY WITNESS	
[Name]		[Address]		[Phone]	
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[Name]		[Address]		[Phone]	
202. NAME OF SIXTY-SECOND WITNESS		203. ADDRESS OF SIXTY-SECOND WITNESS		204. TELEPHONE OF SIXTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
205. NAME OF SIXTY-THIRD WITNESS		206. ADDRESS OF SIXTY-THIRD WITNESS		207. TELEPHONE OF SIXTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
208. NAME OF SIXTY-FOURTH WITNESS		209. ADDRESS OF SIXTY-FOURTH WITNESS		210. TELEPHONE OF SIXTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
211. NAME OF SIXTY-FIFTH WITNESS		212. ADDRESS OF SIXTY-FIFTH WITNESS		213. TELEPHONE OF SIXTY-FIFTH WITNESS	
[Name]		[Address]		[Phone]	
214. NAME OF SIXTY-SIXTH WITNESS		215. ADDRESS OF SIXTY-SIXTH WITNESS		216. TELEPHONE OF SIXTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
217. NAME OF SIXTY-SEVENTH WITNESS		218. ADDRESS OF SIXTY-SEVENTH WITNESS		219. TELEPHONE OF SIXTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
220. NAME OF SIXTY-EIGHTH WITNESS		221. ADDRESS OF SIXTY-EIGHTH WITNESS		222. TELEPHONE OF SIXTY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
223. NAME OF SIXTY-NINTH WITNESS		224. ADDRESS OF SIXTY-NINTH WITNESS		225. TELEPHONE OF SIXTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
226. NAME OF SEVENTY WITNESS		227. ADDRESS OF SEVENTY WITNESS		228. TELEPHONE OF SEVENTY WITNESS	
[Name]		[Address]		[Phone]	
229. NAME OF SEVENTY-FIRST WITNESS		230. ADDRESS OF SEVENTY-FIRST WITNESS		231. TELEPHONE OF SEVENTY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
232. NAME OF SEVENTY-SECOND WITNESS		233. ADDRESS OF SEVENTY-SECOND WITNESS		234. TELEPHONE OF SEVENTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
235. NAME OF SEVENTY-THIRD WITNESS		236. ADDRESS OF SEVENTY-THIRD WITNESS		237. TELEPHONE OF SEVENTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
238. NAME OF SEVENTY-FOURTH WITNESS		239. ADDRESS OF SEVENTY-FOURTH WITNESS		240. TELEPHONE OF SEVENTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
241. NAME OF SEVENTY-FIFTH WITNESS		242. ADDRESS OF SEVENTY-FIFTH WITNESS		243. TELEPHONE OF SEVENTY-FIFTH WITNESS	
[Name]		[Address]		[Phone]	
244. NAME OF SEVENTY-SIXTH WITNESS		245. ADDRESS OF SEVENTY-SIXTH WITNESS		246. TELEPHONE OF SEVENTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
247. NAME OF SEVENTY-SEVENTH WITNESS		248. ADDRESS OF SEVENTY-SEVENTH WITNESS		249. TELEPHONE OF SEVENTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
250. NAME OF SEVENTY-EIGHTH WITNESS		251. ADDRESS OF SEVENTY-EIGHTH WITNESS		252. TELEPHONE OF SEVENTY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
253. NAME OF SEVENTY-NINTH WITNESS		254. ADDRESS OF SEVENTY-NINTH WITNESS		255. TELEPHONE OF SEVENTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
256. NAME OF EIGHTY WITNESS		257. ADDRESS OF EIGHTY WITNESS		258. TELEPHONE OF EIGHTY WITNESS	
[Name]		[Address]		[Phone]	
259. NAME OF EIGHTY-FIRST WITNESS		260. ADDRESS OF EIGHTY-FIRST WITNESS		261. TELEPHONE OF EIGHTY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
262. NAME OF EIGHTY-SECOND WITNESS		263. ADDRESS OF EIGHTY-SECOND WITNESS		264. TELEPHONE OF EIGHTY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
265. NAME OF EIGHTY-THIRD WITNESS		266. ADDRESS OF EIGHTY-THIRD WITNESS		267. TELEPHONE OF EIGHTY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
268. NAME OF EIGHTY-FOURTH WITNESS		269. ADDRESS OF EIGHTY-FOURTH WITNESS		270. TELEPHONE OF EIGHTY-FOURTH WITNESS	
[Name]		[Address]		[Phone]	
271. NAME OF EIGHTY-FIFTH WITNESS		272. ADDRESS OF EIGHTY-FIFTH WITNESS		273. TELEPHONE OF EIGHTY-FIFTH WITNESS	
[Name]		[Address]		[Phone]	
274. NAME OF EIGHTY-SIXTH WITNESS		275. ADDRESS OF EIGHTY-SIXTH WITNESS		276. TELEPHONE OF EIGHTY-SIXTH WITNESS	
[Name]		[Address]		[Phone]	
277. NAME OF EIGHTY-SEVENTH WITNESS		278. ADDRESS OF EIGHTY-SEVENTH WITNESS		279. TELEPHONE OF EIGHTY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
280. NAME OF EIGHTY-EIGHTH WITNESS		281. ADDRESS OF EIGHTY-EIGHTH WITNESS		282. TELEPHONE OF EIGHTY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
283. NAME OF EIGHTY-NINTH WITNESS		284. ADDRESS OF EIGHTY-NINTH WITNESS		285. TELEPHONE OF EIGHTY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
286. NAME OF NINETY WITNESS		287. ADDRESS OF NINETY WITNESS		288. TELEPHONE OF NINETY WITNESS	
[Name]		[Address]		[Phone]	
289. NAME OF NINETY-FIRST WITNESS		290. ADDRESS OF NINETY-FIRST WITNESS		291. TELEPHONE OF NINETY-FIRST WITNESS	
[Name]		[Address]		[Phone]	
292. NAME OF NINETY-SECOND WITNESS		293. ADDRESS OF NINETY-SECOND WITNESS		294. TELEPHONE OF NINETY-SECOND WITNESS	
[Name]		[Address]		[Phone]	
295. NAME OF NINETY-THIRD WITNESS		296. ADDRESS OF NINETY-THIRD WITNESS		297. TELEPHONE OF NINETY-THIRD WITNESS	
[Name]		[Address]		[Phone]	
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[Name]		[Address]		[Phone]	
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[Name]		[Address]		[Phone]	
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[Name]		[Address]		[Phone]	
307. NAME OF NINETY-SEVENTH WITNESS		308. ADDRESS OF NINETY-SEVENTH WITNESS		309. TELEPHONE OF NINETY-SEVENTH WITNESS	
[Name]		[Address]		[Phone]	
310. NAME OF NINETY-EIGHTH WITNESS		311. ADDRESS OF NINETY-EIGHTH WITNESS		312. TELEPHONE OF NINETY-EIGHTH WITNESS	
[Name]		[Address]		[Phone]	
313. NAME OF NINETY-NINTH WITNESS		314. ADDRESS OF NINETY-NINTH WITNESS		315. TELEPHONE OF NINETY-NINTH WITNESS	
[Name]		[Address]		[Phone]	
316. NAME OF ONE HUNDRED WITNESS		317. ADDRESS OF ONE HUNDRED WITNESS		318. TELEPHONE OF ONE HUNDRED WITNESS	
[Name]		[Address]		[Phone]	
319. NAME OF ONE HUNDRED AND ONE WITNESS		320. ADDRESS OF ONE HUNDRED AND ONE WITNESS		321. TELEPHONE OF ONE HUNDRED AND ONE WITNESS	
[Name]		[Address]		[Phone]	
322. NAME OF ONE HUNDRED AND TWO WITNESS		323. ADDRESS OF ONE HUNDRED AND TWO WITNESS		324. TELEPHONE OF ONE HUNDRED AND TWO WITNESS	
[Name]		[Address]		[Phone]	
325. NAME OF ONE HUNDRED AND THREE WITNESS		326. ADDRESS OF ONE HUNDRED AND THREE WITNESS		327. TELEPHONE OF ONE HUNDRED AND THREE WITNESS	
[Name]		[Address]		[Phone]	
328. NAME OF ONE HUNDRED AND FOUR WITNESS		329. ADDRESS OF ONE HUNDRED AND FOUR WITNESS		330. TELEPHONE OF ONE HUNDRED AND FOUR WITNESS	
[Name]		[Address]		[Phone]	
331. NAME OF ONE HUNDRED AND FIVE WITNESS		332. ADDRESS OF ONE HUNDRED AND FIVE WITNESS		333. TELEPHONE OF ONE HUNDRED AND FIVE WITNESS	
[Name]		[Address]		[Phone]	
334. NAME OF ONE HUNDRED AND SIX WITNESS		335. ADDRESS OF ONE HUNDRED AND SIX WITNESS		336. TELEPHONE OF ONE HUNDRED AND SIX WITNESS	
[Name]		[Address]		[Phone]	
337. NAME OF ONE HUNDRED AND SEVEN WITNESS		338. ADDRESS OF ONE HUNDRED AND SEVEN WITNESS		339. TELEPHONE OF ONE HUNDRED AND SEVEN WITNESS	
[Name]		[Address]		[Phone]	
340. NAME OF ONE HUNDRED AND EIGHT WITNESS		341. ADDRESS OF ONE HUNDRED AND EIGHT WITNESS		342. TELEPHONE OF ONE HUNDRED AND EIGHT WITNESS	
[Name]		[Address]		[Phone]	
343. NAME OF ONE HUNDRED AND NINE WITNESS		344. ADDRESS OF ONE HUNDRED AND NINE WITNESS		345. TELEPHONE OF ONE HUNDRED AND NINE WITNESS	
[Name]		[Address]		[Phone]	
346. NAME OF ONE HUNDRED AND TEN WITNESS		347. ADDRESS OF ONE HUNDRED AND TEN WITNESS		348. TELEPHONE OF ONE HUNDRED AND TEN WITNESS	
[Name]		[Address]		[Phone]	
349. NAME OF ONE HUNDRED AND ELEVEN WITNESS		350. ADDRESS OF ONE HUNDRED AND ELEVEN WITNESS		351. TELEPHONE OF ONE HUNDRED AND ELEVEN WITNESS	
[Name]		[Address]		[Phone]	
352. NAME OF ONE HUNDRED AND TWELVE WITNESS		353. ADDRESS OF ONE HUNDRED AND TWELVE WITNESS		354. TELEPHONE OF ONE HUNDRED AND TWELVE WITNESS	
[Name]					

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6620

CERTIFICATE OF DEATH

06572

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>267 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHURCH HILL</b> d. STREET ADDRESS <b>—</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>D.</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 60</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/95</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>GOLDSBORO, MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS BROWN</b>		14. MOTHER'S MAIDEN NAME <b>LULA THARP</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>CLIN. REC. VAH BALTO MD FT HOWARD DIVISION</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EPIDERMOID CARCINOMA OF SKIN, FACE, WITH METASTASIS</b> DUE TO <b>191.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>191.3</b> DUE TO (c) <b>191.3</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Cardiovascular Disease (Operations: Excision of Epidermoid Dermatitis Actinic (Carcinoma of Face 8/10/59 Excision left parotid gland 10/25/59))</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>it</b> (this hospital) attended the deceased from <b>Sept. 28, 1959</b> to <b>June 21, 1960</b> , that <b>we</b> last saw the deceased alive on <b>June 21, 1960</b> , and that death occurred at <b>1:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clyde B. Cope</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/22/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. - FT HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6-24-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive</b>			
23d. LOCATION (City, town, or county) <b>Felton, Delaware</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Boulaia</b>		ADDRESS <b>Greensboro MD</b>		25a. REC'D BY REGISTRAR <b>JUN 24 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06573

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>150 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>P. O. Box 40</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MORRIS</b> Middle <b>C.</b> Last <b>BUTLER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 11, 1892</b>	
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min. <b>60</b>		IF UNDER 24 HRS. Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min. <b>60</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Fisherman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>		11. BIRTHPLACE (State or foreign country) <b>Oxford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Morris C. Butler</b>				14. MOTHER'S MAIDEN NAME <b>Mary Fields</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW I 220-03-3314</b>		17. INFORMANT Address <b>Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT KIDNEY WITH METASTASES TO THE</b> <b>ADRENALS, LUNGS, LIVER AND PERIAORTIC LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>TUMOR THROMBOSIS OF THE RIGHT RENAL VEIN AND VENA CAVA</b> (c) <b>EDEMA OF THE LUNGS</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>RECENT</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MODERATE GENERALIZED ARTERIOSCLEROSIS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>January 31, 1960</b> to <b>June 29, 1960</b> , that (we) lost the deceased alive on <b>June 29, 1960</b> , and that death occurred at <b>8:40p</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Clyde B. Cope</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/30/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>				22d. ADDRESS <b>M.D. VAH, BALTO. 18 MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Removal</b>		23b. DATE THEREOF <b>7/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Talbot County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>				ADDRESS <b>1808 N. Monroe St. Baltimore 17, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>Jul 7 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

SHIPPED TO: St. Clair Funeral Home, Cambridge, Maryland

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CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6622

## CERTIFICATE OF DEATH

06574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. LENGTH OF STAY IN 1b <i>8 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stockton Rd</i>		e. STREET ADDRESS <i>1 Stockton Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Sarah Katherine Byron</i>		4. DATE OF DEATH <i>June 22 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>15 July 1878</i>
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>? EBEN</i>	
14. MOTHER'S MAIDEN NAME <i>?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Wesley Byron</i> Address <i>Phoenix</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic cardio-vascular disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>10 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 1957</i> to <i>June 1960</i> , that I last saw the deceased alive on <i>20 June 1960</i> , and that death occurred on <i>22 June 1960</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>		<i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/25/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>PARK WOOD</i>		22d. LOCATION (City, town, or county) (State) <i>PARKVILLE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ULLRICH FUNERAL HOME 4216 BELAIR</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>JUL 1 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>807 Overbrook Rd.</b>		d. STREET ADDRESS <b>807 Overbrook Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CARELLI</b> Last <b>CARELLI</b>		4. DATE OF DEATH <b>6/27/60</b> Month <b>6</b> Day <b>27</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b> Hours <b>12</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Layer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Prospero Carelli</b>	
14. MOTHER'S MAIDEN NAME <b>Margherita Manfredi</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>161-01-6102</b>		17. INFORMANT <b>Margaret Carelli-807 Overbrook Rd. 12</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>6</b> Day <b>27</b> Year <b>1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6805 York Rd.</b>	20f. (City or town) <b>Baltimore</b> (County) <b>12</b> (State) <b>MD</b>
21. I certify that I attended the deceased from <b>3/2</b> <b>1960</b> to <b>6-27</b> <b>1960</b> , that I last saw the deceased alive on <b>6-27</b> <b>1960</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Laurence C. Post</b>		DATE SIGNED <b>6/27/60</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		ADDRESS (Street, city or town, state) <b>Baltimore 12 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial 7/1/60</b>	22b. DATE THEREOF <b>7/1/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Northwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>North-Philadelphia, Penn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 29 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1d, Film G266 7/5/60 iwk  
6624  
CERTIFICATE OF DEATH

Reg. Dist. No. 06578

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7044 Eastbrook Avenue (pvt. home)</i>		d. STREET ADDRESS <i>7044 Eastbrook Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Frances F. Carroll</i>		4. DATE OF DEATH <i>June 21, 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 8, 1878</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Daniel Weber</i>		14. MOTHER'S MAIDEN NAME <i>??</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mr. Daniel A. Carroll Sr</i>		Address <i>7044 Eastbrook Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardio-vascular disease</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> to <i>June 21, 1960</i> , that I last saw the deceased alive on <i>June 21, 1960</i> , and that death occurred at <i>9 A. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Eugene Zeller</i> M.D. <i>2739 Eastern Ave - Baltimore</i> <i>6/22/60</i> PHYSICIAN'S NAME (Type) <i>Eugene Zeller, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 24, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>		ADDRESS <i>3000 E. Baltimore St.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 24 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6625

CERTIFICATE OF DEATH

06577  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>MD.</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SWAN OAK</u>				c. LENGTH OF STAY IN 1b <u>1 YR.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>CARSTENS</u> Last <u>CARSTENS</u>				4. DATE OF DEATH Month <u>6/8</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/18/1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>68, Campfield</u>	
13. FATHER'S NAME <u>John Ganz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Regina Schlaid</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>68-11-1111</u>		INFORMANT <u>Records AUGSBURG HOME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Carcinoma of colon -</u> <u>153.8</u> DUE TO <u>Anterior-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>5 yrs.</u> (b) <u>Anterior-sclerotic Heart Disease</u> (c) <u>Generalized Anterior-sclerotic</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Anterior-sclerotic</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>59</u> , to <u>June 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>60</u> , and that death occurred at <u>8</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u>				DATE SIGNED <u>4108 Liberty Hts Balto - Md. 6-8-60</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATOR		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6/10/60</u>		<u>St. Pauls Cem.</u>		<u>BALTO MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.A. Heermann</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>			
ADDRESS <u>6067 HARP RD.</u>				DATE <u>JUN 13 '60</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6626 CERTIFICATE OF DEATH 06578

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 BELFAST ROAD</b>		d. STREET ADDRESS <b>15 BELFAST ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B</b> Last <b>CARTER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Greenhouse Worker- Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Florist</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Carter</b>		14. MOTHER'S MAIDEN NAME <b>? Boblitz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>217-12-3034</b>	
17. INFORMANT <b>MRS. GERALDINE ZEMBOWER</b>		Address <b>15 BELFAST RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN</b> <b>5 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>JUNE 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>5-25-1960</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William A. Pillsbury</b>		22b. DATE SIGNED <b>6-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		22d. ADDRESS <b>TIMONIUM MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-16-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FORK METHODIST CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 16 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

114

BALTIMORE

TIMOTHY

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06579

6588

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Watersedge Beach</b>				d. STREET ADDRESS <b>212 Dteroit Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES CLARY CASTIGLIONE</b>				4. DATE OF DEATH Month Day Year <b>June 26, 1960 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1953</b>		9. AGE (In years last birthday) <b>6 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vincebt Castiglione</b>				14. MOTHER'S MAIDEN NAME <b>Joan Neal</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Vincent Castiglione 212 Detroit Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> 929-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stepped from Sand Bar into Bear Creek</b>					
20c. TIME OF INJURY Month, Day, Year <b>6-16-60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bear Creek</b>		20f. City or town (County) (State) <b>Dundalk - Baltimore Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <del>Heart Disease</del> <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. Davis, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CLERK		19. SIGNATURE OF JURY		20. SIGNATURE OF CORONER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF PRIEST		24. SIGNATURE OF MINISTER		25. SIGNATURE OF CHURCH	
26. SIGNATURE OF FUNERAL HOME		27. SIGNATURE OF BURIAL PLACE		28. SIGNATURE OF INTERMENT		29. SIGNATURE OF CREMATION		30. SIGNATURE OF OTHER	
31. SIGNATURE OF HEALTH OFFICIAL		32. SIGNATURE OF VITALS OFFICIAL		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF CLERK		35. SIGNATURE OF JURY	
36. SIGNATURE OF CORONER		37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF PRIEST		40. SIGNATURE OF MINISTER	
41. SIGNATURE OF CHURCH		42. SIGNATURE OF FUNERAL HOME		43. SIGNATURE OF BURIAL PLACE		44. SIGNATURE OF INTERMENT		45. SIGNATURE OF CREMATION	
46. SIGNATURE OF OTHER		47. SIGNATURE OF HEALTH OFFICIAL		48. SIGNATURE OF VITALS OFFICIAL		49. SIGNATURE OF REGISTRAR		50. SIGNATURE OF CLERK	
51. SIGNATURE OF JURY		52. SIGNATURE OF CORONER		53. SIGNATURE OF DECEASED		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF PRIEST	
56. SIGNATURE OF MINISTER		57. SIGNATURE OF CHURCH		58. SIGNATURE OF FUNERAL HOME		59. SIGNATURE OF BURIAL PLACE		60. SIGNATURE OF INTERMENT	
61. SIGNATURE OF CREMATION		62. SIGNATURE OF OTHER		63. SIGNATURE OF HEALTH OFFICIAL		64. SIGNATURE OF VITALS OFFICIAL		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF CLERK		67. SIGNATURE OF JURY		68. SIGNATURE OF CORONER		69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN	
71. SIGNATURE OF PRIEST		72. SIGNATURE OF MINISTER		73. SIGNATURE OF CHURCH		74. SIGNATURE OF FUNERAL HOME		75. SIGNATURE OF BURIAL PLACE	
76. SIGNATURE OF INTERMENT		77. SIGNATURE OF CREMATION		78. SIGNATURE OF OTHER		79. SIGNATURE OF HEALTH OFFICIAL		80. SIGNATURE OF VITALS OFFICIAL	
81. SIGNATURE OF REGISTRAR		82. SIGNATURE OF CLERK		83. SIGNATURE OF JURY		84. SIGNATURE OF CORONER		85. SIGNATURE OF DECEASED	
86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF PRIEST		88. SIGNATURE OF MINISTER		89. SIGNATURE OF CHURCH		90. SIGNATURE OF FUNERAL HOME	
91. SIGNATURE OF BURIAL PLACE		92. SIGNATURE OF INTERMENT		93. SIGNATURE OF CREMATION		94. SIGNATURE OF OTHER		95. SIGNATURE OF HEALTH OFFICIAL	
96. SIGNATURE OF VITALS OFFICIAL		97. SIGNATURE OF REGISTRAR		98. SIGNATURE OF CLERK		99. SIGNATURE OF JURY		100. SIGNATURE OF CORONER	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

6627

06580  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>		c. LENGTH OF STAY IN 1b <u>90 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patrick Henry Walker Caughy, Sr</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15, 1870</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Pikesville 8, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hamilton Caughy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth A. Foreman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-12-5805</u>	
17. INFORMANT <u>Marguerite Caughy</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>51</u> , to <u>June 19</u> , 19 <u>60</u> , that I lost sows the deceased olive on <u>6-13</u> , 19 <u>60</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u>		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u> DATE SIGNED <u>6/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Nemecek</u>		ADDRESS <u>Pikesville 8, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Age: <i>22</i></p>	
<p>5. Date of death: <i>Jan 15, 1922</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Place of death: <i>Home</i></p>		<p>8. Signature of physician: <i>John Doe</i></p>	
<p>9. Signature of registrar: <i>John Doe</i></p>		<p>10. Signature of informant: <i>John Doe</i></p>	
<p>11. Signature of witness: <i>John Doe</i></p>		<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of witness: <i>John Doe</i></p>		<p>14. Signature of witness: <i>John Doe</i></p>	
<p>15. Signature of witness: <i>John Doe</i></p>		<p>16. Signature of witness: <i>John Doe</i></p>	
<p>17. Signature of witness: <i>John Doe</i></p>		<p>18. Signature of witness: <i>John Doe</i></p>	
<p>19. Signature of witness: <i>John Doe</i></p>		<p>20. Signature of witness: <i>John Doe</i></p>	
<p>21. Signature of witness: <i>John Doe</i></p>		<p>22. Signature of witness: <i>John Doe</i></p>	
<p>23. Signature of witness: <i>John Doe</i></p>		<p>24. Signature of witness: <i>John Doe</i></p>	
<p>25. Signature of witness: <i>John Doe</i></p>		<p>26. Signature of witness: <i>John Doe</i></p>	
<p>27. Signature of witness: <i>John Doe</i></p>		<p>28. Signature of witness: <i>John Doe</i></p>	
<p>29. Signature of witness: <i>John Doe</i></p>		<p>30. Signature of witness: <i>John Doe</i></p>	
<p>31. Signature of witness: <i>John Doe</i></p>		<p>32. Signature of witness: <i>John Doe</i></p>	
<p>33. Signature of witness: <i>John Doe</i></p>		<p>34. Signature of witness: <i>John Doe</i></p>	
<p>35. Signature of witness: <i>John Doe</i></p>		<p>36. Signature of witness: <i>John Doe</i></p>	
<p>37. Signature of witness: <i>John Doe</i></p>		<p>38. Signature of witness: <i>John Doe</i></p>	
<p>39. Signature of witness: <i>John Doe</i></p>		<p>40. Signature of witness: <i>John Doe</i></p>	
<p>41. Signature of witness: <i>John Doe</i></p>		<p>42. Signature of witness: <i>John Doe</i></p>	
<p>43. Signature of witness: <i>John Doe</i></p>		<p>44. Signature of witness: <i>John Doe</i></p>	
<p>45. Signature of witness: <i>John Doe</i></p>		<p>46. Signature of witness: <i>John Doe</i></p>	
<p>47. Signature of witness: <i>John Doe</i></p>		<p>48. Signature of witness: <i>John Doe</i></p>	
<p>49. Signature of witness: <i>John Doe</i></p>		<p>50. Signature of witness: <i>John Doe</i></p>	
<p>51. Signature of witness: <i>John Doe</i></p>		<p>52. Signature of witness: <i>John Doe</i></p>	
<p>53. Signature of witness: <i>John Doe</i></p>		<p>54. Signature of witness: <i>John Doe</i></p>	
<p>55. Signature of witness: <i>John Doe</i></p>		<p>56. Signature of witness: <i>John Doe</i></p>	
<p>57. Signature of witness: <i>John Doe</i></p>		<p>58. Signature of witness: <i>John Doe</i></p>	
<p>59. Signature of witness: <i>John Doe</i></p>		<p>60. Signature of witness: <i>John Doe</i></p>	
<p>61. Signature of witness: <i>John Doe</i></p>		<p>62. Signature of witness: <i>John Doe</i></p>	
<p>63. Signature of witness: <i>John Doe</i></p>		<p>64. Signature of witness: <i>John Doe</i></p>	
<p>65. Signature of witness: <i>John Doe</i></p>		<p>66. Signature of witness: <i>John Doe</i></p>	
<p>67. Signature of witness: <i>John Doe</i></p>		<p>68. Signature of witness: <i>John Doe</i></p>	
<p>69. Signature of witness: <i>John Doe</i></p>		<p>70. Signature of witness: <i>John Doe</i></p>	
<p>71. Signature of witness: <i>John Doe</i></p>		<p>72. Signature of witness: <i>John Doe</i></p>	
<p>73. Signature of witness: <i>John Doe</i></p>		<p>74. Signature of witness: <i>John Doe</i></p>	
<p>75. Signature of witness: <i>John Doe</i></p>		<p>76. Signature of witness: <i>John Doe</i></p>	
<p>77. Signature of witness: <i>John Doe</i></p>		<p>78. Signature of witness: <i>John Doe</i></p>	
<p>79. Signature of witness: <i>John Doe</i></p>		<p>80. Signature of witness: <i>John Doe</i></p>	
<p>81. Signature of witness: <i>John Doe</i></p>		<p>82. Signature of witness: <i>John Doe</i></p>	
<p>83. Signature of witness: <i>John Doe</i></p>		<p>84. Signature of witness: <i>John Doe</i></p>	
<p>85. Signature of witness: <i>John Doe</i></p>		<p>86. Signature of witness: <i>John Doe</i></p>	
<p>87. Signature of witness: <i>John Doe</i></p>		<p>88. Signature of witness: <i>John Doe</i></p>	
<p>89. Signature of witness: <i>John Doe</i></p>		<p>90. Signature of witness: <i>John Doe</i></p>	
<p>91. Signature of witness: <i>John Doe</i></p>		<p>92. Signature of witness: <i>John Doe</i></p>	
<p>93. Signature of witness: <i>John Doe</i></p>		<p>94. Signature of witness: <i>John Doe</i></p>	
<p>95. Signature of witness: <i>John Doe</i></p>		<p>96. Signature of witness: <i>John Doe</i></p>	
<p>97. Signature of witness: <i>John Doe</i></p>		<p>98. Signature of witness: <i>John Doe</i></p>	
<p>99. Signature of witness: <i>John Doe</i></p>		<p>100. Signature of witness: <i>John Doe</i></p>	

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>54RS. 6 Mo.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3V01-4</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		d. STREET ADDRESS <b>1110 E. NORTH AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HENDERSON CLARK</b>		4. DATE OF DEATH Month Day Year <b>JUNE 20 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 13, 1950</b>
9. AGE (In years lost birthday) yrs. <b>10</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JERRY BASS</b>	
14. MOTHER'S MAIDEN NAME <b>MARY ROSE SMITH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. ADDRESS <b>ROSEWOOD RECORDS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-enteritis, acute, etiology not determined.</b> DUE TO 513X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Inanition</b> (c) <b>Bronchiectasis and otitis media, chronic.</b> (d) <b>Chronic sinusitis (bilateral)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital cerebral defect with symptomatic epilepsy. (Dipligic) - Birth</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/19/60</b> , 19 <b>60</b> , to <b>6/20/60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/20/60</b> , 19 <b>60</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE: <b>Harry B. Butler M.D.</b>		ADDRESS (Street, city or town, state) <b>Rosewood State Training School</b> DATE SIGNED <b>6/21/60</b>	
PHYSICIAN'S NAME (Type) <b>Harry E. Butler, M.D.</b>		Cwings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-21-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>mt. Calvary Cem.</b>	22d. LOCATION (City, town, county) (State) <b>H. A. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. A. Jackson</b>		24. REC'D BY REGISTRAR <b>9/6 Penna</b> DATE <b>JUN 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLYNDON</b>		c. LENGTH OF STAY IN 1b <b>2 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WORTHINGTON HILL DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET JENNINGS CLARK</b>		4. DATE OF DEATH <b>JUNE 17 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 15 - 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM JENNINGS</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE DEXTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. J. PARKER CLARK</b>		Address <b>347 ROSEBANK AVE. BALT 12, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cardiac decompensation</b> DUE TO (c) <b>Arteriosclerotic C.V. Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>12 months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10</b> , 19 <b>60</b> to <b>June 17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>60</b> , and that death occurred at <b>6 A.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		ADDRESS (Street, city or town, state) <b>48 Main Street</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>		<b>Reisterstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 20, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CHURCH CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>TEXAS, BALTIMORE COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. JENKINS &amp; SONS CO</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b> DATE	
ADDRESS <b>4905 YORK ROAD BALT. 12, MD</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0800

(M)

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CHECKED

NAME OF REVIEWED

NAME OF APPROVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6629

## CERTIFICATE OF DEATH

Reg. Dist. No. 06583

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Herman Middle Cohen Last Cohen</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1885</b>
9. AGE (In years lost birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown Retail</b>		10b. HAND OR BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13. FATHER'S NAME <b>unknown ABRAHAM COHEN</b>		14. MOTHER'S MAIDEN NAME <b>unknown ESTHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>217-16-8059</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarctive myocardial fibrosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 19 60</b> to <b>June 30 1960</b> , that I last saw the deceased alive on <b>June 30, 19 60</b> , and that death occurred at <b>8:10a. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-30-60</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 6-30-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/1/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bnai Israel Cong.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>SOL LEVINSON &amp; BROS INC. 6010 Reisterstown Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>			

1000

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06584**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>514 Club Lane</b>				d. STREET ADDRESS <b>514 Club Lane</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ESTHER</b> <b>N.</b> <b>CONNELL</b>				<b>4. DATE OF DEATH</b> <b>June 26, 1960</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>Feb. 21, 1881</b>			
<b>9. AGE</b> (In years last birthday) <b>79</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Mississippi</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>Jeff. B. Naugle</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Florence Battle</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>461-32-9451</b>		<b>17. INFORMANT</b> <b>Address</b> <b>(Mrs.) Geo. D. Bennett, 514 Club Lane</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420-1</b> <b>DUE TO</b> <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO</b> Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Charles F. O'Donnell</b>		<b>EXAMINER'S NAME (Type)</b> <b>Charles F. O'Donnell</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>22b. DATE THEREOF</b> <b>6/28/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Restland Mem. Pk.</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Dallas, Texas</b>		<b>22e. (State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm Cook-Towson, Inc.</b>		<b>ADDRESS</b> <b>1050 York Rd. Towson</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUN 28 1960</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>		<b>DATE</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10-10-1964



6631

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3715 Sylvan Drive, Balto. 7, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3715 Sylvan Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clara</b> First <b>Cummings</b> Middle Last				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1884</b>	9. AGE (In years last birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pittston, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Martin Quinn</b>			14. MOTHER'S MAIDEN NAME <b>Clara Cadman</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Louise Mitchell, 3715 Sylvan Drive, ZONE 7</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>153.1</b> IMMEDIATE CAUSE (a) <b>Carcinoma of transverse colon</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>19 Jan</b> , 19 <b>60</b> , to <b>13 June</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9 June</b> , 19 <b>60</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Marvin H. Davis</b> M.D. <b>6512 Liberty Road</b> PHYSICIAN'S NAME (Type) <b>Marvin H. Davis, M. D.</b> <b>Baltimore 7, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6-13-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pittston Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittston, Pennsylvania</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b> Md. </b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Baltimore (Halethorpe)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>1 1264 Francis Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elson</b> Middle <b>B.</b> Last <b>Daugharthy</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1880</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Sheet Metal</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hamburg, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George B. Daugharthy</b>		14. MOTHER'S MAIDEN NAME <b>Ann Butler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Son</b> Address <b>Dr. A.B. Daugharthy 1264 Francis Ave. #27</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>none</b> <b>10 yrs</b> <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1958</b> to <b>June 21, 1960</b> that (I) (we) last saw the deceased alive on <b>June 21, 1960</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Bradley Daugharthy</b>		22b. DATE SIGNED <b>6-22-60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/26/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Russell, Penn.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 24 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

8833

Baltimore

Baltimore

1. Lowry Manor Road, Home

Bison

Male White

Net. Sheet Metal

George E. Dushanin

Ann Butler

Son

Dr. A. B. Dushanin 1234 Transylvania

Burial 20.00 Pine Grove Cemetery, Russell, Tenn.

Howard H. Hubbard 412 Wilkins Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6633

CERTIFICATE OF DEATH

Reg. Dist. No. 06587

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5207 Garmouth Rd.</b>		d. STREET ADDRESS <b>5207 Garmouth Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen Marie</b> Middle <b>Degele</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>T.V. Station</b>	11. BIRTHPLACE (State or foreign country) <b>Penn.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Charles deHass</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE BERTRAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>John E. Degele 5207 Garmouth Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive - Cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1955</b> 19 to <b>June 25, 1960</b> that I last saw the deceased alive on <b>June 18, 1960</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2108 St Paul St Baltimore Md</b> DATE SIGNED <b>6/28/60</b>			
ACTUAL SIGNATURE <b>Homer W. Todd</b> M.D.		DATE SIGNED <b>6/28/60</b>	
PHYSICIAN'S NAME (Type) <b>Homer W. Todd</b>		<b>Baltimore Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-29-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home - Catonsville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

(14)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06588

6634

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3401-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armcast Nursing Home</i>		d. STREET ADDRESS <i>2942 Green Mount Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs. Martha De Vos</i>		4. DATE OF DEATH <i>June 30th 19 60</i>	
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 3, 1889</i>	
9. AGE (In years lost birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Patrick o'Brien</i>		14. MOTHER'S MAIDEN NAME <i>Regina ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Mr. John R. De Vos, Sr.</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X Cerebral Vascular Accident</i> DUE TO <i>Hypertensive Arteriosclerotic Cardio-vascular Disease</i> DUE TO <i>Diabetes Mellitus, Carcinoma, Cervix</i> DUE TO <i>2 yrs.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1955</i> to <i>June 30, 1960</i> , that I last saw the deceased alive on <i>28 June 19 60</i> , and that death occurred at <i>9A. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6011 York Rd. Balt. 12 Md.</i> DATE SIGNED <i>1 July 60</i>			
ACTUAL SIGNATURE <i>Wm. H. Kammer, Jr.</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Wm. H. Kammer, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/2/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 5 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knecht</i>	

உதவி: அப்பா, அம்மா!

உருகியவன், உருகியவன்

1990

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06589

Reg. Dist. No.

6635

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>305 Holly Drive (20)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>JOHN</b> Last <b>DeWAR, SR.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 9, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Vacuum Cleaners</b>	
11. BIRTHPLACE (State or foreign country) <b>Ontario, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Laudlin DeWar</b>		14. MOTHER'S MAIDEN NAME <b>Katie Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-015181</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>4200</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M. B. Davis</b> EXAMINER'S NAME (Type) <b>MELVIN DAVIS, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>				22d. LOCATION (City, town, or county) <b>Baltimore</b>		22e. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6636

## CERTIFICATE OF DEATH

Reg. Disf. No.

06590

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore (Merridale)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor for Aged &amp; Con.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bertie L. Dienhart</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 60.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Rudolph H. Dienhart</b>		Address <b>632 Plymouth Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> 19 <b>52</b> , to <b>June</b> 19 <b>60</b> , that I last saw the deceased alive on <b>May 20</b> 19 <b>60</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo J. Gaver, M.D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1 Mallow Hill Ave. 6/7/60</b>	
PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>		<b>Baltimore 29, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-10-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Howard Strong, Brother of the Deceased</b>		24a. REC'D BY REGISTRAR DATE <b>Jun 13 60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>John Doe</b></p>		<p>2. Date of death: <b>10-15-1969</b></p>	
<p>3. Age: <b>45</b></p>		<p>4. Sex: <b>Male</b></p>	
<p>5. Race: <b>White</b></p>		<p>6. Marital status: <b>Married</b></p>	
<p>7. Usual residence: <b>123 Main St, Baltimore, MD</b></p>		<p>8. Place of death: <b>Home</b></p>	
<p>9. Cause of death: <b>Heart Disease</b></p>		<p>10. Manner of death: <b>Natural</b></p>	
<p>11. Physician: <b>Dr. J. Smith</b></p>		<p>12. Coroner: <b>Mr. Brown</b></p>	
<p>13. Burial place: <b>Greenwood Cemetery</b></p>		<p>14. Signature of physician: <b>[Signature]</b></p>	
<p>15. Signature of coroner: <b>[Signature]</b></p>		<p>16. Date of filing: <b>10-16-1969</b></p>	



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6637

STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06591

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>54</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>523 MARYLAND AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARROLL</b> Middle <b>W.</b> Last <b>DOETZER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11-1908</b>
9. AGE (In years lost birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPV.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WESTERN ELECTRO</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE J. DOETZER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA WAGNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>415-10-4138</b>	
17. INFORMANT <b>MARY A. DOETZER - SAME AS ABOVE</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY ARTERY DISEASE</b> DUE TO (c) <b>5 YRS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>55</b> to <b>6/24</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>5/23</b> 19 <b>60</b> , and that death occurred at <b>1100 PM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Miceli</b>		22b. DATE SIGNED <b>6/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI MD.</b>		22d. ADDRESS <b>108 S. TAYLOR AVE BALTO. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6-28-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>	23d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connolly</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 28 '60</b>	
ADDRESS <b>418 Eastern Blvd. Balto. 21,</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Cinder Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1037 York Road</b>				d. STREET ADDRESS <b>Timonium,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles George Dorfler</b>				4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1914</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouse Shipping Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>H.T. Campbell Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George F. Dorfler</b>				14. MOTHER'S MAIDEN NAME <b>Bertha A. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-97-7510</b>		17. INFORMANT Address <b>Mrs. Margaret Dorfler, 51 Cinder Rd., Timonium</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____            DUE TO _____ (c) _____</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Timonium, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1991, 1992, 1993

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1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 25

TO HOSPITAL: 1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6639

CERTIFICATE OF DEATH

06593

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore County</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>2011 CALLOW AVENUE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>VIRGIE</u> Middle <u>HAROLD</u> Last <u>DOUGHERTY</u>		<b>4. DATE OF DEATH</b> Month <u>JUNE</u> Day <u>25</u> Year <u>1960</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MARCH 15 1911</u>
<b>9. AGE</b> (In years lost birthday) <u>49</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>1</u> Hours <u>4</u> Min. <u>4</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>VIRGINIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>JOHN FRITZ</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH ROBERTS</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>	
<b>17. INFORMANT</b> <u>Hospital Records, Mt. Wilson State Hospital</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO (b) <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>002X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sclerosis of Liver and Tuberculosis of Adrenal Gland</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>6/24</u> , 19 <u>60</u> , to <u>6/25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/25</u> , 19 <u>60</u> , and that death occurred at <u>7:40</u> P. M., from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>William Newcomer</u>		<b>DATE SIGNED</b> <u>Mt. Wilson, Maryland</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>Wm. Newcomer, M.D. Superintendent</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>6-28-60</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peters Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUN 28 '60</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>			

CERTIFICATE OF

DEATH

JOHN J. PATTERSON

ALLIANCE

JOHN J. PATTERSON

JOHN J. PATTERSON

JOHN J. PATTERSON

JOHN J. PATTERSON

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JOHN J. PATTERSON

JOHN J. PATTERSON



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06594

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (19)</u> d. STREET ADDRESS <u>23 Bowers Farm Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WILLIAM</u> Middle <u>C.</u> Last <u>DRYER</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>15</u> Year <u>1960</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 10, 1918</u>		<b>9. AGE</b> (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Steel Company</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>WILLIAM DRYER (Deceased)</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>? Kraft (Deceased)</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				<b>16. SOCIAL SECURITY NO.</b> <u>27-01-1816</u>		<b>17. INFORMANT</b> <u>Clinical Records</u> Address <u>VAH, Baltimore, Md. Fort Howard Division</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO <u>Coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> <u>11 yrs.</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>[Signature]</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>SAK C. Collins</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<u>6-16-60</u>	
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6-20-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> ADDRESS <u>Connelly Funeral Home, 418 Eastern Ave. Baltimore 21, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>JUN 20 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		COLOR [REDACTED]		RELIGION [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
MEDICAL HISTORY [REDACTED]		PRESENT ILLNESS [REDACTED]		TREATMENT [REDACTED]	
PHYSICIAN'S SIGNATURE [REDACTED]		MEDICAL EXAMINER'S SIGNATURE [REDACTED]		DATE [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	

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may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 6641 CERTIFICATE OF DEATH

06595

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6400 Bellona Ave</u>				c. LENGTH OF STAY IN 1b <u>15 mon.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Masey Villa</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford</u>			
f. STREET ADDRESS <u>3605 Turkey Lane</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Marie</u> Last <u>Turner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1871</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Benjamin J. Schelling</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>219-14-0178A</u>		17. INFORMANT <u>Mrs. Harry Ford</u>		Address <u>106 St. Theresas Road.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized, advanced.</u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u> <u>Indefinite</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1956</u> to <u>June 27, 1960</u> , that (I) <u>  </u> last saw the deceased alive on <u>June 25, 1960</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward F. Cotter</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD F. COTTER</u>				22d. ADDRESS <u>6 E. READ ST. Balto 2, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons - Balto 17 Md</u>				25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUN 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

Full name of deceased

Age

Sex

Color

Marital status

Place of birth

Usual residence

Occupation

Cause of death

Time of death

Place of death

Signature of physician

Signature of registrar

Signature of informant

Signature of witness

Signature of undertaker

Signature of funeral home

Signature of cemetery

Signature of church

Signature of school

Signature of hospital

Signature of doctor

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6642

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06596

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>5 YEARS-3mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRIET S EDWARDS</b>		4. DATE OF DEATH <b>JUNE 7 1960</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1873</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE B. SKINNER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE WINGATE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 years.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-11 1955</b> , to <b>6-6 1960</b> , that (I) (we) last saw the deceased alive on <b>6-6 1960</b> , and that death occurred at <b>8:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>6/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-10-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b> ADDRESS <b>1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 9 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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100-100000

100-100000



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Life pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/56

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06597

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>5 wks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1733 Wentworth Ave.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON 4, C</b> d. STREET ADDRESS <b>1 8545 Water Oak Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patrick Vernon Elgin</b>				4. DATE OF DEATH Month Day Year <b>June 25, 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Wh.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 21, 1960</b>	
9. AGE (in years last birthday) yrs. <b>35</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Richard Elgin</b>				14. MOTHER'S MAIDEN NAME <b>Patricia Miles</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Richard Elgin, 8545 Water Oak Road, Towson 4</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> 492 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>WOLKUS</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>June 26, 1960</b>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-29-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR <b>William Cook, Inc., 1217 St. Paul Street</b>				ADDRESS			
24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

2047261XV4

THE STATE  
OF NEW YORK



RECEIVED  
JAN 1 1960

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
ALBANY, NEW YORK  
JAN 1 1960  
DEATH CERTIFICATE  
No. 1000  
Name: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Date of Birth: [illegible]  
Date of Death: [illegible]  
Place of Birth: [illegible]  
Cause of Death: [illegible]  
Signature: [illegible]  
Official Seal: [illegible]

**1**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Accepted Charles T. Somerville*

**VS A15 (4)  
15M 9/55**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6644**  
**CERTIFICATE OF DEATH**  
**06598**  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Home</b>		d. STREET ADDRESS <b>405 Alabama Rd. Towson</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>J.</b> Last <b>ESCHMANN</b>		4. DATE OF DEATH <b>June 29, 1960</b> Month <b>June</b> Day <b>29</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1869</b> 9. AGE (In years last birthday) <b>90</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscape Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gardening</b>	11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>
13. FATHER'S NAME <b>Jacob Eschmann</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>139-26-9879</b> 17. INFORMANT <b>Walter G. Eschmann</b> Address <b>405 Alabama Rd. Towson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 BRONCHOPNEUMONIA</b> DUE TO (b) <b>INANITION</b> DUE TO (c) <b>CARDIAC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>2 WEEKS</b> <b>YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE, LEFT FEMORAL NECK</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL DOWN CLIMBING OUT OF BED.</b>	
20c. TIME OF INJURY Month <b>6</b> Day <b>3</b> Year <b>1960</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NURSING HOME</b>	20f. (City or town) <b>TOWSON</b> (County) <b>BALTIMORE</b> (State) <b>MD.</b>
21. I certify that I attended the deceased from <b>2/8, 1957</b> to <b>6/29, 1960</b> , that I last saw the deceased alive on <b>6/29, 1960</b> , and that death occurred at <b>9:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald L. Somerville</b> M.D.		ADDRESS (Street, city or town, state) <b>25 W. PENNA. AVE</b> DATE SIGNED <b>6/30/60</b>	
PHYSICIAN'S NAME (Type) <b>Donald L. Somerville, M.D.</b>		<b>Towson &amp; Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>7/2/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc.</b> ADDRESS <b>1050 York Rd. Towson</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>

CERTIFICATE OF DEATH

See this for

<p>NAME OF DECEASED</p> <p>AGE</p> <p>SEX</p> <p>RACE</p> <p>DATE OF BIRTH</p> <p>PLACE OF BIRTH</p> <p>DATE OF DEATH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>DATE OF BURIAL</p> <p>PLACE OF BURIAL</p> <p>NAME OF MINISTER</p> <p>NAME OF FUNERAL HOME</p> <p>NAME OF CEMETERY</p> <p>NAME OF INTERVIEWER</p> <p>DATE OF INTERVIEW</p> <p>PLACE OF INTERVIEW</p> <p>NAME OF WITNESS</p> <p>DATE OF WITNESS</p> <p>PLACE OF WITNESS</p> <p>NAME OF SIGNER</p> <p>DATE OF SIGNATURE</p> <p>PLACE OF SIGNATURE</p> <p>NAME OF OFFICIAL</p> <p>DATE OF OFFICIAL</p> <p>PLACE OF OFFICIAL</p> <p>NAME OF CLERK</p> <p>DATE OF CLERK</p> <p>PLACE OF CLERK</p> <p>NAME OF ASSISTANT</p> <p>DATE OF ASSISTANT</p> <p>PLACE OF ASSISTANT</p> <p>NAME OF RECORDER</p> <p>DATE OF RECORDER</p> <p>PLACE OF RECORDER</p> <p>NAME OF INDEXER</p> <p>DATE OF INDEXER</p> <p>PLACE OF INDEXER</p> <p>NAME OF FILED</p> <p>DATE OF FILED</p> <p>PLACE OF FILED</p> <p>NAME OF CLERK</p> <p>DATE OF CLERK</p> <p>PLACE OF CLERK</p> <p>NAME OF ASSISTANT</p> <p>DATE OF ASSISTANT</p> <p>PLACE OF ASSISTANT</p> <p>NAME OF RECORDER</p> <p>DATE OF RECORDER</p> <p>PLACE OF RECORDER</p> <p>NAME OF INDEXER</p> <p>DATE OF INDEXER</p> <p>PLACE OF INDEXER</p> <p>NAME OF FILED</p> <p>DATE OF FILED</p> <p>PLACE OF FILED</p>		<p>NAME OF DECEASED</p> <p>AGE</p> <p>SEX</p> <p>RACE</p> <p>DATE OF BIRTH</p> <p>PLACE OF BIRTH</p> <p>DATE OF DEATH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>DATE OF BURIAL</p> <p>PLACE OF BURIAL</p> <p>NAME OF MINISTER</p> <p>NAME OF FUNERAL HOME</p> <p>NAME OF CEMETERY</p> <p>NAME OF INTERVIEWER</p> <p>DATE OF INTERVIEW</p> <p>PLACE OF INTERVIEW</p> <p>NAME OF WITNESS</p> <p>DATE OF WITNESS</p> <p>PLACE OF WITNESS</p> <p>NAME OF SIGNER</p> <p>DATE OF SIGNATURE</p> <p>PLACE OF SIGNATURE</p> <p>NAME OF OFFICIAL</p> <p>DATE OF OFFICIAL</p> <p>PLACE OF OFFICIAL</p> <p>NAME OF CLERK</p> <p>DATE OF CLERK</p> <p>PLACE OF CLERK</p> <p>NAME OF ASSISTANT</p> <p>DATE OF ASSISTANT</p> <p>PLACE OF ASSISTANT</p> <p>NAME OF RECORDER</p> <p>DATE OF RECORDER</p> <p>PLACE OF RECORDER</p> <p>NAME OF INDEXER</p> <p>DATE OF INDEXER</p> <p>PLACE OF INDEXER</p> <p>NAME OF FILED</p> <p>DATE OF FILED</p> <p>PLACE OF FILED</p>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6645

## CERTIFICATE OF DEATH

06599  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Kingsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1453 Washington Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Marie</u> Last <u>Farrell</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick J. McGinley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mansel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs Thomas A. Brandt</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> <u>1922X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Melanoma - ret - eye</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3</u> , 19 <u>60</u> , to <u>June 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-22</u> , 19 <u>60</u> , and that death occurred at <u>11:22</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Medical Center, Towson Plaza</u> DATE SIGNED ACTUAL SIGNATURE <u>Eugene J. Riley</u> M.D. PHYSICIAN'S NAME (Type) <u>Eugene J. Riley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Altoona, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Leonard J. Ruck</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 (Corrected by phone) 7-7-60 et

## CERTIFICATE OF DEATH

6646

Reg. Dist. No.

06600

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point (19)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point (19)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>916 E Street</b>				d. STREET ADDRESS <b>916 E. Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JOSEPH</b> Last <b>FITZGERALD, Sr.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22nd</b> Year <b>19 60</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1892</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Fitzgerald</b>				14. MOTHER'S MAIDEN NAME <b>Anna Manion</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-9451</b>		17. INFORMANT <b>Mrs. L.J. Hursh</b> Address <b>same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Hypertensive arteriosclerotic Cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>1 day</b> <b>18 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1960, June 22, 1960</b> , that I last saw the deceased alive on <b>June 22, 1960</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>914 D Street</b> DATE SIGNED <b>6/23/60</b>							
ACTUAL SIGNATURE <b>John V. Conway</b>		M.D. <b>914 D Street</b>					
PHYSICIAN'S NAME (Type) <b>John W. Conway, M.D.</b>		<b>Sparrows Point 19, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Brooks Bradley, Jr.</b>				ADDRESS <b>Dundalk 22, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	
				24c. REC'D BY REGISTRAR <b>JUN 28 '60</b>			

# CERTIFICATE OF DEATH

4446

<p>1. Name of deceased: <b>John Thomas Harrison</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>Jan 21, 1895</b></p>		<p>4. Age: <b>30</b></p>	
<p>5. Place of birth: <b>London, England</b></p>		<p>6. Usual residence: <b>101-102nd St., Astoria, Ore.</b></p>	
<p>7. Cause of death: <b>Heart disease</b></p>		<p>8. Date of death: <b>Jan 21, 1925</b></p>	
<p>9. Time of death: <b>10:30 P.M.</b></p>		<p>10. Place of death: <b>Home</b></p>	
<p>11. Signature of physician: <b>W. H. Harrison</b></p>		<p>12. Signature of registrar: <b>W. H. Harrison</b></p>	
<p>13. Signature of informant: <b>W. H. Harrison</b></p>		<p>14. Signature of witness: <b>W. H. Harrison</b></p>	



MADE IN U.S.A.  
 101-102ND ST., ASTORIA, ORE.  
 JAN 21, 1925  
 W. H. HARRISON

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6648

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06602

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>23 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3857 Forest Park Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>Jacob</b> Last <b>FORSHLAGER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1892</b> <b>October 15, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>insalment</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Abraham Forshlager</b>				14. MOTHER'S MAIDEN NAME <b>Bluma MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANEURYSM, ABDOMINAL, RUPTURED</b> DUE TO <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>451X</b> (c) <b>Unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE &amp; RECENT MYOCARDIAL INFARCTION</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that (a) (this hospital) attended the deceased from <b>May 8</b> to <b>June 1</b> , 1960 that (b) (we) last saw the deceased alive on <b>June 1</b> , 1960, and that death occurred at <b>10:10</b> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Clyde B. Cope</b>				22b. DATE SIGNED <b>6/1/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 3/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Tfillloh</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson, Reistertown and Pinkney Rds. Balto. Md. &amp; Bros. Inc.</b>				25a. REC'D BY REGISTRAR <b>June 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

BP

[Faint, mostly illegible text from a criminal record document, possibly a list of offenses or case details.]

6647

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Gwynnbrook Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Lavina</b> Last <b>Frank</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1880</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>William Scott</b>				14. MOTHER'S MAIDEN NAME <b>Emma Bosley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Perry A. Frank, Owings Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident - Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December, 1958</b> , to <b>June 3, 1960</b> , that I last saw the deceased alive on <b>June 3, 1960</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence E. McElhiney</b>		M.D. <b>1194 Eastertown Rd. Eastertown, Md.</b>		ADDRESS (Street, city or town, state) <b>1194 Eastertown Rd. Eastertown, Md.</b>		DATE SIGNED <b>June 4, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Clarence E. McElhiney</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

6837

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan. 1, 1900</i></p>		<p>4. Place of birth: <i>St. Louis, Mo.</i></p>	
<p>5. Date of death: <i>Jan. 15, 1950</i></p>		<p>6. Place of death: <i>St. Louis, Mo.</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in place of item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Noos

FOR STATE  
HEALTH DEPT.

1  
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X  
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3

1  
M  
X  
2  
3

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6649

06603

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN 1b <b>4 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sparrows Point Dispensary</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> d. STREET ADDRESS <b>511 E Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEROY</b> Middle <b>JAMES</b> Last <b>GARRISON</b>			4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 60</b>			
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Jan. 14, 1960</b>			
9. AGE (In years last birthday) <b>5</b>			10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>			
11. IF UNDER 24 HRS. Hours <b>5</b> Min. <b>5</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Balto. Md. ck</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Kiem</b>			14. MOTHER'S MAIDEN NAME <b>Maxine Garrison</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Maxine Garrison</b>			Address <b>511 E. Street 19</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis</b> DUE TO (b) <b>Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> DUE TO (c) <b>Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Charles S. Petty</b>			M.D. <b>Charles S. Petty, M.D.</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>6/21/60</b>			Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6-23-1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>			22d. LOCATION (City, town, or country) (State) <b>German Hill Rd. Md.</b>			
23. FUNERAL DIRECTOR <b>JOHN J. DUDA</b>			ADDRESS <b>7922 Wise Ave. 22, Md.</b>			
24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**6650**

**06604**

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>1647 Milton Ave 13</b>			
3. NAME OF DECEASED (Type or print) <b>GLADDEN, CHARLES</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
First Middle Last				4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/28/1911</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>4</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>			
11. BIRTHPLACE (State or foreign country) <b>Winnsboro S.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Daniel Gladden</b>				14. MOTHER'S MAIDEN NAME <b>Bertha ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-09-1204</b>		17. INFORMANT <b>Blanche Gladden</b> Address <b>1647 Milton Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b>							
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-U Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. B. Davis</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>6/5/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>June 8/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Winnsboro S. Carolina</b>				22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <b>Milton S. Ellicker</b> ADDRESS <b>1129 N. Caroline St</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Howard</b>			
				24b. REGISTRAR'S SIGNATURE <b>DATE JUN 8 '60</b>			

MEDICAL CERTIFICATION

**2**

**M**

**1**

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6651  
CERTIFICATE OF DEATH  
06606

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORTT HOWARD</b> c. LENGTH OF STAY IN 1b <b>57 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>607 Harvey Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>K.</b> Last <b>GODDARD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 31, 1876</b>
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Casey, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Godard</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> SAW		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Balto. Md. Ft. Howard Div</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRCULATORY HYPOTENSION</b> <b>467.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>POST OPERATIVE COMPLICATIONS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMPHYSEMA. CHRONIC BRAIN SYNDROME, CARCINOMA OF SIGMOID</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(x)</b> (this hospital) attended the deceased from <b>April 18, 1960</b> , to <b>June 14, 1960</b> , that <b>(x)</b> (we) last saw the deceased alive on <b>June 14, 1960</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence D. Marcus</b>		22b. DATE SIGNED <b>6/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE, MD. - FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-18-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James McGully, 128 E. Fort Ave. Balto 30, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 16 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>			



60332

0031

NAME

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT



## CERTIFICATE OF DEATH

Reg. Dist. No. **06607****6593**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CARNEY</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2454 ELLIS ROAD</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CARNEY.</b> d. STREET ADDRESS <b>12454 ELLIS ROAD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>GOOCH</b> Last <b>GOOCH</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 6 1894</b>	
9. AGE (In years lost birthday) <b>65 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		11. BIRTHPLACE (State or foreign country) <b>CROWN CORK &amp; SEAL WASH D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM GOOCH</b>				14. MOTHER'S MAIDEN NAME <b>MILLIE JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>1st WW.</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>ADELINE M. GOOCH-2454 ELLIS ROAD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>amyotrophic lateral sclerosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH <b>3yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Jan.</b> , 19 <b>60</b> , to <b>June 13, 1960</b> that I last saw the deceased alive on <b>June 12</b> , 19 <b>60</b> , and that death occurred at <b>5<sup>00</sup></b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Harold A. Grott</b> M.D. <b>8100 Harford Rd</b>							
PHYSICIAN'S NAME (Type) <b>HAROLD A. GROTT, M.D. Balto., Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>OLD FREDERICK RD MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan</b> ADDRESS <b>3818 Plantine</b>				24a. REC'D BY REGISTRAR <b>JUN 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

CERTIFICATE OF DEATH

2502

DATE OF DEATH

Cause

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PROPERTY

DEATH

TESTIMONY

SIGNATURE

WITNESSES

NOTARY

REMARKS

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1

6652

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06668

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. LENGTH OF STAY IN 1b <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>422 Ingleside</i>		d. STREET ADDRESS <i>422 Ingleside</i>	
3. NAME OF DECEASED (Type or print) <i>William E. Gover</i>		4. DATE OF DEATH <i>June 9 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/11/09</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jesse Gover</i>		14. MOTHER'S MAIDEN NAME <i>Effie Hatfield</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217 01 5805</i>	
17. INFORMANT <i>Mamie Reich Gover</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>Arteriosclerotic cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 yrs +</i> <i>5 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <i>1953</i> to <i>6-9</i> 1960, that (I) (we) last saw the deceased alive on <i>6-7</i> 1960, and that death occurred at <i>6:45</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>John A. Nesbitt, Jr.</i>		22b. DATE SIGNED <i>6-9-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT, JR</i>		22d. ADDRESS <i>1118 St Paul St. Baltimore 2, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>6/11/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>	23d. LOCATION (City, town, or county) (State) <i>Catonville</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Don</i>		25. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	
25a. REC'D BY REGISTRAR		DATE <i>JUN 13 '60</i>	

10000

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

1885

(M)

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6653

**CERTIFICATE OF DEATH**

06609

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>				c. LENGTH OF STAY IN 1b <b>8/3/59</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park, Maryland</b> 18X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Irving</b> Middle <b>Pete</b> Last <b>Harley</b>		4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>19 60</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/43</b>	9. AGE (In years last birthday) <b>17</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Matthew Harley</b>				14. MOTHER'S MAIDEN NAME <b>Iola Agatha Harvey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> 353.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>(Chronic sinusitis with basalar infiltration)</b> DUE TO (c) <b>Epilepsy (seizure) grand mal type</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-day</b> <b>5-months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diplegia with injury at birth with symptomatic epilepsy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>6/20/60</b> to <b>6/23/60</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>6/23/60</b> 19 <b>60</b> , and that death occurred at <b>2:40 p.m.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Harry G. Butler M.D.</b>		22b. DATE SIGNED <b>6/24/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>		22d. ADDRESS <b>Rosewood Training School, Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-27-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>		23d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home, Waldorf, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Fries</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

6654

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06610

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>115 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1927 Brunt Street BALTIMORE (17) 3V01.4</b> d. STREET ADDRESS <b>1927 Brunt Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CRAWFORD</b> Middle <b>---</b> Last <b>HAYES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 30, 1906</b> 9. AGE (In years last birthday) <b>53</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b> 11. BIRTHPLACE (State or foreign country) <b>South Carolina</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Payton Hayes</b>		14. MOTHER'S MAIDEN NAME <b>Lulu Tate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>213-12-6635</b>		17. INFORMANT <b>Clin. Records, VAH, Balto. 18, Md. Fort Howard Division</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GANGRENE, LUNGS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>BRONCHOPNEUMONIA, BILATERAL</b> (c) <b>CARCINOMA OF TONGUE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease, duration unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 26, 1960</b> to <b>June 20, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 20, 1960</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>C. B. Cope, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>		22b. DATE SIGNED <b>6/22/60</b> 22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/25/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Arbutus Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips, 1808 N. Monroe St.</b>		25a. REC'D BY REGISTRAR <b>JUN 24 '60</b> 25b. REGISTRAR'S SIGNATURE <b>Arlington S. Phillips</b>	

Baltimore 17, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6655

CERTIFICATE OF DEATH

Reg. Dist. No.

06611

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>22 Woodlawn Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>R.</b> Last <b>Heagerty</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1865</b>
9. AGE (In years last birthday) yrs. <b>94</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>94</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Emmanuel Geer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Owens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. Francis Albert</b>		Address <b>22 Woodlawn Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General arteriosclerosis</b> lying cause lost. (c) <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 1960</b> to <b>June 1960</b> that I last saw the deceased alive on <b>6/18/60</b> and that death occurred at <b>7:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Catonsville, Md.</b> DATE SIGNED <b>June 28 '60</b>			
ACTUAL SIGNATURE <b>Christina Mass</b>			
PHYSICIAN'S NAME (Type) <b>St. John's Professional Center Ellicott City, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-21-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home, Catonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6656

## CERTIFICATE OF DEATH

Reg. Dist. No.

06612

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>35 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res., 7218 Bay Front Road 22</b>		e. STREET ADDRESS <b>7218 Bay Front Road</b>	
3. NAME OF DECEASED (Type or print) <b>Laura</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert T. Burgess</b>		14. MOTHER'S MAIDEN NAME <b>Annie M. Callahan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-2323D</b>	
17. INFORMANT <b>Mrs. Lillian R. Barry</b>		Address <b>7218 Bay Front Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>463 X</b> IMMEDIATE CAUSE (a) <b>Hydrostatic Pneumonia</b> DUE TO <b>C.V.A.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Length of time after Extremities</b> (c) <b>7 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 days</b> <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1950, to <b>June 7</b> , 1960, that I last saw the deceased alive on <b>June 7</b> , 1960, and that death occurred at <b>6:00</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James T. Means</b>		ADDRESS (Street, city or town, state) <b>520 D St. Balt 19404</b>	
PHYSICIAN'S NAME (Type) <b>James T. Means</b>		DATE SIGNED <b>6/8/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEROF <b>6-11-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Georges</b>		22d. LOCATION (City, town, or county) (State) <b>New Castle Co. Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>	

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6657

06613

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1223 Stevens Ave. #27			
3. NAME OF DECEASED (Type or print)		First Middle Last		Ferdinand Hellmann	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
male		white			
8. DATE OF DEATH		Month Day Year		June 22, 1960	
9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY?	
74 yrs.		Germany		U. S. A.	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		12c. BIRTHPLACE (State or foreign country)	
Ret. Maint. Man		Cont. Can Co.		Germany	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Jacob Hellmann		Margaret Hartung			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
no		214-03 4402		Margaret Hellmann 1223 Stevens Ave. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		19. INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral arteriosclerosis		2 mo.	
DUE TO		Generalized arteriosclerosis		Herdit.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO			
		Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 1960, to June 22, 1960, that (I) (we) lost saw the deceased alive on June 22, 1960, and that death occurred at 7 PM, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED	
A. Bradley Daugharthy		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		6-22-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
A. Bradley Daugharthy		1264 Rrancis Avenue #27			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/25/60		Loudon Park Cemetery	
23d. LOCATION (City, town, or county) (State)				Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard		JUN 24 '60		Arthur S. Hines	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06614

Reg. Dist. No.

6589

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	c. LENGTH OF STAY in 1b <b>* 20 b</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lodge Forest</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Point Road, Auto Accdnt.</b>		d. STREET ADDRESS <b>2407 Woodridge Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KAY</b> Middle <b>FRANCES</b> Last <b>HELSEL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1938</b>
9. AGE (in years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min. <b>23</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fuse Capper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harold E. Helsel</b>		14. MOTHER'S MAIDEN NAME <b>Louise Rightnour</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>208-28-6271</b>	
17. INFORMANT <b>Mr. Harold E. Helsel</b>		Address <b>2407 Woodridge</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound Fracture of Skull</b> DUE TO (b) <b>to loss of total Brain Tissue</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car was Struck Broadside by Tractor Trailer</b>	
20c. TIME OF INJURY Month, Day, Year <b>10 - 6 - 23 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>North Blvd</b>	20f. (City or town) (County) (State) <b>BALTO - 24 - BALTO - MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>6/23/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-26-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Langdondale Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Langdondale, Bedford, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06615

6595

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Relay Hill Hospital</b>		d. STREET ADDRESS <b>208 W. Franklin Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Carolyn</b> Middle <b>Hastings</b> Last <b>Henshaw</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 11, 1889</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Udupiddi, Ceylon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard C. Hastings</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Truax</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Richard F. Cleveland-4110 Greenway Baltimore</b>		Address <b>Bel. 5-9322</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia both lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Cerebral vascular accident (thrombosis) with right hemiplegia</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>May 12, 1960</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis with arteriosclerosis several years</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 3, 1958</b> , to <b>June 6, 1960</b> , that I last saw the deceased alive on <b>June 6, 1960</b> , and that death occurred at <b>11:30 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Relay, 27, Md.</b> DATE SIGNED <b>6-6-60</b>			
ACTUAL SIGNATURE <b>Lewis P. Gundry</b> M.D.		PHYSICIAN'S NAME (Type) <b>Lewis P. Gundry, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>6/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 9 '60</b>	
ADDRESS <b>4905 York Road; Balto., Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Areo Acres #20</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Areo Acres #20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Propeller Drive</u>			d. STREET ADDRESS <u>24 Compass Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE A. HINES</u>			4. DATE OF DEATH Month Day Year <u>June 9, 19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1898</u>		9. AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Mayes</u>			14. MOTHER'S MAIDEN NAME <u>Lidia Reecer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>245-30-8293</u>		17. INFORMANT <u>Ernest R. Hines</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V-Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>Areo Acres</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>MB Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/9/60</u>	
EXAMINER'S NAME (Type) <u>Dr. Melvin Davis</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stephens Funeral Home</u>	
22d. LOCATION (City, town, or county) <u>Lumberton, N.C.</u>		22e. (State) <u>N.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>		ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur P. Thomas</u>					

MEDICAL CERTIFICATION



6828

TEXAS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED: _____</p>	
<p>AGE: _____</p>	
<p>SEX: _____</p>	
<p>DATE OF DEATH: _____</p>	
<p>PLACE OF DEATH: _____</p>	
<p>CAUSE OF DEATH: _____</p>	
<p>MANNER OF DEATH: _____</p>	
<p>TIME OF DEATH: _____</p>	
<p>PLACE OF BURIAL: _____</p>	
<p>NAME OF FUNERAL HOME: _____</p>	
<p>NAME OF PHYSICIAN: _____</p>	
<p>NAME OF MEDICAL EXAMINER: _____</p>	
<p>SIGNATURE OF MEDICAL EXAMINER: _____</p>	
<p>DATE OF EXAMINATION: _____</p>	
<p>TIME OF EXAMINATION: _____</p>	
<p>PLACE OF EXAMINATION: _____</p>	
<p>NAME OF WITNESS: _____</p>	
<p>SIGNATURE OF WITNESS: _____</p>	
<p>DATE OF WITNESS: _____</p>	
<p>TIME OF WITNESS: _____</p>	
<p>PLACE OF WITNESS: _____</p>	
<p>NAME OF DECEASED: _____</p>	
<p>AGE: _____</p>	
<p>SEX: _____</p>	
<p>DATE OF DEATH: _____</p>	
<p>PLACE OF DEATH: _____</p>	
<p>CAUSE OF DEATH: _____</p>	
<p>MANNER OF DEATH: _____</p>	
<p>TIME OF DEATH: _____</p>	
<p>PLACE OF BURIAL: _____</p>	
<p>NAME OF FUNERAL HOME: _____</p>	
<p>NAME OF PHYSICIAN: _____</p>	
<p>NAME OF MEDICAL EXAMINER: _____</p>	
<p>SIGNATURE OF MEDICAL EXAMINER: _____</p>	
<p>DATE OF EXAMINATION: _____</p>	
<p>TIME OF EXAMINATION: _____</p>	
<p>PLACE OF EXAMINATION: _____</p>	
<p>NAME OF WITNESS: _____</p>	
<p>SIGNATURE OF WITNESS: _____</p>	
<p>DATE OF WITNESS: _____</p>	
<p>TIME OF WITNESS: _____</p>	
<p>PLACE OF WITNESS: _____</p>	

## 06617

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1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ARMACOST NURSING HOME 812 REGESTER AVE</b>		d. STREET ADDRESS <b>4230 LOCH RAVEN BLVD.</b>	
3. NAME OF DECEASED (Type or print) <b>First: ELsie Middle: E. Last: HOCH</b>		4. DATE OF DEATH Month: <b>JUNE</b> Day: <b>23</b> Year: <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 19, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months: Days: Hours: Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LEGAL</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS HOCH</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE GERHOLD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-01-4575</b>	
17. INFORMANT <b>NORMAN GERHOLD</b>		Address <b>5813 GYNN OAK AVE ZONE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1960</b> to <b>June 23, 1960</b> that (I) (we) last saw the deceased alive on <b>June 17, 1960</b> and that death occurred at <b>2:27 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. S. Chalfant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. S. CHALFANT</b>		22d. ADDRESS <b>6810 YORK ROAD Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JUNE 27, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. JENKINS &amp; SONS CO</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>	
ADDRESS <b>4905 YORK ROAD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06619

6660

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>6 Hr. 40 M.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RODERICK</b>		First <b>RODERICK</b>		Middle <b>---</b>		Last <b>HOLMES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Work</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Roderick Holmes</b>		14. MOTHER'S MAIDEN NAME <b>Winnie Epps</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-05-9868</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>		Address <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEURYSM, AORTA</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>June 16, 3:00 P.M.</b>		(County) (State)	
21. I certify that <b>VAH</b> (this hospital) attended the deceased from <b>June 16, 3:00 P.M.</b> to <b>June 16, 1960</b> , that <b>VAH</b> (we) last saw the deceased alive on <b>June 16, 1960</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Clyde B. Cope</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/28/60</b>					
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Elliott Funeral Home</b>		ADDRESS <b>1129 N. Caroline St.</b>		DATE <b>JUN 30 '60</b>		25a. REC'D BY REGISTRAR <b>William S. Finner</b>		25b. REGISTRAR'S SIGNATURE	
		<b>Baltimore, Md.</b>							

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Commissioner of the General Land Office

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06620

6661

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN 1b ---?---			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				d. STREET ADDRESS <u>3113 Cresson Av., Baltimore 7</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>LEE</u> Last <u>HONG Sr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Chinese</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>About 1886</u>	
9. AGE (In years last birthday) <u>Abt 74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>San Francisco, Calif.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>could not ascertain</u>				14. MOTHER'S MAIDEN NAME <u>could not ascertain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>113-36-2953</u>		17. INFORMANT Address <u>Tom Lee Hong (son) 3113 Cresson Av. (7)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>181.0</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from <u>8-27-</u> 19 <u>56</u> , to <u>6-22-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-22-</u> 19 <u>60</u> , and that death occurred on <u>6-23-</u> <u>A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Miller Chiu</u>				DATE SIGNED <u>6-23-60</u>			
PHYSICIAN'S NAME (Type) <u>Chi-Chao Chiu, M. D.</u>				ADDRESS (Street, city or town, state) <u>1 E. Randall St., Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June-25-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Baltimore 7.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart &amp; Mowen Co., 108-W-North-Balto. 1.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G266 7/5/60 iwk

Reg. Dist. No.

06621

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8 AVENAL ROAD</b>			d. STREET ADDRESS <b>8 AVENAL ROAD</b>		
3. NAME OF DECEASED (Type or print) <b>WALTER LOUIS HOOPER</b>			4. DATE OF DEATH <b>JUNE 25 1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/17/1909</b>		9. AGE (In years last birthday) <b>50</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPTICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BOWEN &amp; KING</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13. FATHER'S NAME <b>WALTER HOOPER</b>		
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		
16. SOCIAL SECURITY NO. <b>NW 2 577-03-5369</b>			17. INFORMANT <b>VIRGINIA MEARS HOOPER, WIFE, ABOVE</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound (22 Cal.) thru</b> <b>976x</b> DUE TO <b>low chin up into Brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Shot Surv err Cal. Bullet thru chin + head</b>			
20c. TIME OF INJURY <b>11:19 a.m.</b> Month, Day, Year <b>6/25 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Essex</b> (County) <b>Baltimore</b> (State) <b>MD.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6/27/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Schummer</b>		ADDRESS <b>3331 BREHNS LANE</b>		24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

1  
6663  
MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 11,12 FilmG265 6-20-60 et  
6663  
CERTIFICATE OF DEATH

06622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arplington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudwood Sanatorium Towson 4, Maryland</b>		d. STREET ADDRESS <b>4330-S. 36th St</b>	
3. NAME OF DECEASED (Type or print) First <b>Belle</b> Middle <b>B</b> Last <b>Howell</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1860</b>
9. AGE (In years lost birthday) <b>99 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Blanchard</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Blaidell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Personal History</b>		Address <b>Hospital Records, Eudwood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.4</b> DUE TO <b>Cardiac decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Cardiac Senility</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec-16-</b> 19 <b>55</b> , to <b>June 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 13</b> , 19 <b>60</b> , and that death occurred at <b>7:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>		<b>Eudwood Sanatorium, Towson 4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL &amp; TRANSIT 6-16-60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>		22d. LOCATION (City, town, or county) (State) <b>CHICAGO, ILLINOIS</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN O. MITCHELL &amp; SONS, INC. 1900 E. LAW PL.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>			

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6664

06623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>14yrlmth25dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>2500 E. Frankford Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>(ELSA)</u> Last <u>Huber</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glenn L. Martin Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Otto Huber</u>		14. MOTHER'S MAIDEN NAME <u>Hedwig Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>214-40-6814</u>	
17. INFORMANT <u>Records; SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. had trephine operation performed at 6:00 p.m. on 6-6-60</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. was found on 6-6-60 lying on floor convulsing with a large lump on right side of head.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> o. m. <u>  </u> p. m. <u>  </u> <u>6-6-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) <u>Catonsville 28, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>6-7-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/9/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harley Miller</u>		ADDRESS <u>2334 Jefferson St</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>705 S. 50th St.</b>				d. STREET ADDRESS <b>705 S. 50th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET E. HUGHES</b>				4. DATE OF DEATH <b>June 29,</b>		Day Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1889</b>		9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred White</b>				14. MOTHER'S MAIDEN NAME <b>Shillings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles Hughes 705 S. 50th St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>422.1</b> DUE TO <b>ARTERIO-SCLEROTIC CARDIO-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>VASCULAR DISEASE</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>16 DAYS</b> <b>5 YRS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 15, 1960</b> , to <b>JUNE 29, 1960</b> , that I last saw the deceased alive on <b>JUNE 25, 1960</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph Miceli</b>				ADDRESS (Street, city or town, state) <b>108 S. TAYLOR AVE</b>			
PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI, M.D.</b>				DATE SIGNED <b>BALTIMORE 21, MD 7/1/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>				ADDRESS <b>Ullrich Funeral Home Dundalk, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hanna</b>	
24a. REC'D BY REGISTRAR <b>JUL 5 '60</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18



1. NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		2. SEX [Faint text, possibly "Male"]		3. AGE [Faint text, possibly "45"]		4. DATE OF BIRTH [Faint text, possibly "1910-01-01"]	
5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		6. OCCUPATION [Faint text, possibly "Teacher"]		7. MARITAL STATUS [Faint text, possibly "Married"]		8. DATE OF MARRIAGE [Faint text, possibly "1935-06-15"]	
9. PLACE OF DEATH [Faint text, possibly "Home"]		10. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		11. MANNER OF DEATH [Faint text, possibly "Natural"]		12. DATE OF DEATH [Faint text, possibly "1960-03-10"]	
13. SIGNATURE OF DECEASED [Faint signature]		14. SIGNATURE OF WITNESS [Faint signature]		15. SIGNATURE OF PHYSICIAN [Faint signature]		16. SIGNATURE OF CLERK [Faint signature]	
17. PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]		18. DATE OF INTERMENT [Faint text, possibly "1960-03-12"]		19. NAME OF INTERMENT SOCIETY [Faint text, possibly "St. Mary's"]		20. NAME OF MINISTER [Faint text, possibly "Rev. John Smith"]	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6666

## CERTIFICATE OF DEATH

06625

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>146 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1823 N. Linden Avenue</b>		(17)	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>C.</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 23, 1910</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>4</b>		IF UNDER 24 HRS. Days <b>16</b>		Hours <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pickle Company</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Day</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>214-05-1320</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md., Ft Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG, WITH REMOTE METASTASES</b> (b) <b>EMPHYSEMA, RIGHT LUNG</b> (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>June 16, 1960</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>		20i. (Country) <b>U. S. A.</b>	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>January 22, 1960</b> to <b>June 16, 1960</b> , that <b>he</b> (we) last saw the deceased alive on <b>June 16, 1960</b> , and that death occurred at <b>11:30 A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clyde B. Cope</b>				22b. DATE <b>6/16/60</b>		22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. SIGNATURE <b>Arthur S. Haines</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore Maryland</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Phillips, 1308 N. Monroe St., Balto.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

252

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6667  
66626  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Annes</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELSON</b> Middle <b>---</b> Last <b>JACOBS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1894</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Centreville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Frazier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-14-4395</b>	
17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE RENAL FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>RUPTURED ARTERIOSCLEROTIC ABDOMINAL ANEURYSM</b> DUE TO (c) <b>Operation 6/8/60 Resection - Ruptured abdominal aneurysm (teflon graft) replacement</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 7</b> <b>6:15</b> <b>60</b> to <b>June 12</b> <b>1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 12</b> <b>1960</b> , and that death occurred at <b>p</b> M, from the causes and on the date stated above.		22b. DATE SIGNED <b>6/13/60</b>	
22a. SIGNATURE <b>Clyde B. Cope, M.D.</b>		22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-13-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Corsica Neck Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Corsica Neck, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips, 1808 N. Monroe St., Balto.</b>		25a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

SHIPPED TO: St. Clair Funeral Home, Cambridge, Md.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible] 2. Sex: [illegible] 3. Age: [illegible]

4. Date of death: [illegible] 5. Place of death: [illegible]

6. Cause of death: [illegible]

7. Signature of physician: [illegible]

8. Signature of registrar: [illegible]

9. Signature of informant: [illegible]

10. Date of registration: [illegible]

11. Place of registration: [illegible]

12. Signature of registrar: [illegible]

13. Signature of informant: [illegible]

14. Date of registration: [illegible]

15. Place of registration: [illegible]

16. Signature of registrar: [illegible]

17. Signature of informant: [illegible]

18. Date of registration: [illegible]

19. Place of registration: [illegible]

20. Signature of registrar: [illegible]

21. Signature of informant: [illegible]

22. Date of registration: [illegible]

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06627

## CERTIFICATE OF DEATH

Reg. Dist. No.

6668

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>28 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>2525 N. McComas Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Sarah</u> Middle <u>James</u> Last <u>James</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-09</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>60</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. . California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rosenthal</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Janowitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cariac failure</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity; schizophrenic reaction paranoid type</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25</u> , 19 <u>60</u> , to <u>June 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruno Radauskas</u>				ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u>			
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>				DATE SIGNED <u>6/11/60</u> <u>Baltimore 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Ave. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u>				ADDRESS <u>7922 Wise Ave. 22, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH                  [Faint text, possibly "10-15-1918"]</p>	
<p>5. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>6. CAUSE OF DEATH                  [Faint text, possibly "Pneumonia"]</p>	
<p>7. OCCASION OF DEATH                  [Faint text, possibly "While on duty"]</p>		<p>8. SIGNATURE OF PHYSICIAN                  [Faint text, possibly "J. H. Smith"]</p>	
<p>9. SIGNATURE OF WITNESS                  [Faint text, possibly "A. B. Jones"]</p>		<p>10. SIGNATURE OF REGISTRAR                  [Faint text, possibly "C. D. Brown"]</p>	
<p>11. PLACE OF BIRTH                  [Faint text, possibly "Maryland"]</p>		<p>12. DATE OF BIRTH                  [Faint text, possibly "10-15-1873"]</p>	
<p>13. OCCUPATION                  [Faint text, possibly "Soldier"]</p>		<p>14. SERVICE                  [Faint text, possibly "U.S. Army"]</p>	
<p>15. GRAVE                  [Faint text, possibly "Arlington National Cemetery"]</p>		<p>16. OTHER NOTES                  [Faint text, possibly "Deceased was a member of the U.S. Army..."]</p>	

may be required by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

6669

06628

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>22 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1039 Rutland Street (5)</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>---</b> Last <b>JATER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1960</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 19, 1892</b>		9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b> Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>Farmville, Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Emanuel Jater</b>				14. MOTHER'S MAIDEN NAME <b>Ada Wylie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 1</b>				17. INFORMANT <b>Clin. Records, VAH, Balto. 18, Md., Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>260X</b> IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> DUE TO <b>GANGRENE, LEFT FOOT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>DIABETES MELLITUS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 10 Dys.</b> <b>Unknown</b> <b>Unknown</b>	
MEDICAL CERTIFICATION 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Other significant conditions contributing to death but not related to the terminal disease condition given in Part I (a): <b>Operation Above Knee Amputation 5/23/60 HYPERTENSION; OBESITY. GENERALIZED ARTERIO SCLEROSIS</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that <b>(M)</b> (this hospital) attended the deceased from <b>May 16</b> <b>1960</b> to <b>June 7</b> <b>1960</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>June 7</b> <b>1960</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Clyde B. Cope</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>6/8/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-10-60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore Maryland</b>			
23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ho lland Funeral Home, 1631 Druid Hill Ave.</b>				ADDRESS <b>Baltimore, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 10 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

2833



6670

## CERTIFICATE OF DEATH

06629  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>50 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. JOSEPH'S NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERTHA B. JESIONOWSKA (SOBUL)</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-1896</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>7</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LANGRALL'S CANNING CO. CANNERY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FRANCES BIELIK</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-03-4817</b>	
17. INFORMANT <b>MRS. EVA BURCA</b>		Address <b>615 S. MONTFORD AVE.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism - multiple</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Pulmonary fibrosis -</b> DUE TO <b>HTC VD -</b> (c) <b>12 hrs</b> <b>3+ yrs</b> <b>10+ yrs</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from <b>Jan</b> , 1960, to <b>June</b> , 1960, that I last saw the deceased alive on <b>6/7</b> , 1960, and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Victor F. Zing</b> M.D.	DATE SIGNED <b>1102 E. Jopson Rd, Towson MD 6/8/60</b>
PHYSICIAN'S NAME (Type) <b>1102 E. Jopson Rd, Towson MD 6/8/60</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-11-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY BALTIMORE CT. MD.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond L. Kaczynski</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.



## CERTIFICATE OF DEATH

06630  
Reg. Dist. No. 32

6671

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>3001.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MEREDITH PARKER JONES</b>		4. DATE OF DEATH Month Day Year <b>JUNE 25 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 12, 1900</b>		9. AGE (In years last birthday) <b>59 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIP RIGGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP REPAIRS</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>EDWARD LEE JONES</b>		14. MOTHER'S MAIDEN NAME <b>MARY HARLOW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-12-6602</b>		INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>630 A</b>	
20f. (City or town) <b>BALTIMORE</b>		(County) <b>MD</b>		(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>Sept. 18, 1958</b> to <b>June 25, 1960</b> , that I last saw the deceased alive on <b>June 25, 1960</b> , and that death occurred at <b>6:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>William Newcomer</b> PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-28-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. PETERS CEMT.</b>	
22d. LOCATION (City, town, or county) <b>BALTIMORE</b>		(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.M. Cook Inc.</b>		ADDRESS <b>1217 ST. PAUL ST.</b>		24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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## CERTIFICATE OF DEATH

Reg. Dist. No. 06631

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b <i>Monkton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Katherine Robb Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>LILLIAN AGNES Jorss</i>		4. DATE OF DEATH Month Day Year <i>June 2 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 3, 1879</i>
9. AGE (In years lost birthday) yrs. <i>81</i>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Francis McShane</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Bradley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>C. Rogers Jorss</i>		Address <i>609 Milford Mill Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i>few years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3:45</i> , 19 <i>50</i> , to <i>2 June</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1 June</i> , 19 <i>60</i> , and that death occurred at <i>11:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H Royse</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>808 Reisterstown Rd. 3 June 60</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H ROYSE</i>		<i>Pikesville 8 rd.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/6/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		ADDRESS <i>4600 Liberty Hgts. Ave.</i>	
24a. REC'D BY REGISTRAR <i>JUN 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

0072

Bartholomew Co. Ind.

Franklin

Bartholomew's Road, West of Frank

11 Jan 1973

1 Jan 1973

Maryland

Bartholomew

C. Rogers Jones - 609 Milford Hill Rd.

Jones

No.

in recorded information  
of the deceased's residence  
at the time of death.

Bartholomew Co. Ind.  
Bartholomew Co. Ind.  
Bartholomew Co. Ind.

Bartholomew Co. Ind.  
Bartholomew Co. Ind.  
Bartholomew Co. Ind.



## CERTIFICATE OF DEATH

Reg. Dist. No.

06632

6673

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHERN</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3208 ST. LUKES LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH MARIE KEEHNER</u>				4. DATE OF DEATH Month Day Year <u>JUNE 5 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 28, 1869</u>	
9. AGE (In years lost birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>			
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John MEYER</u>				14. MOTHER'S MAIDEN NAME <u>Sophia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>				16. SOCIAL SECURITY NO. <u>216-09-9250</u>			
17. INFORMANT <u>MARY MEDINGER</u>				Address <u>3208 ST. LUKES LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arterio-sclerosis</u> <u>450.10</u> DUE TO <u>Age</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Blindness in both eyes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 1957</u> to <u>June 3, 1960</u> , that I last saw the deceased alive on <u>June 3, 1960</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Volenick</u> M.D.				ADDRESS (Street, city or town, state) <u>4710 Liberty St. Ar</u>			
PHYSICIAN'S NAME (Type) <u>Lee J. Volenick M.D.</u>				DATE SIGNED <u>June 8 60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-8-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE L. SCHWAB FUNERAL HOME</u> <u>Francis W. Miller 2101 Frederick Ave.</u> <u>Balto., Md.</u>				24. REC'D BY REGISTRAR DATE <u>JUN 8 60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

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CHIEF V. B. C.

100-100000

100-100000

STATE OF NEW YORK  
COUNTY OF ALBANY  
In SENATE  
January 10, 1900  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899  
ALBANY: J. B. CROSBY & CO. PRINTERS  
1900

6674  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>27yr9mth27dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>(Gordon)</b> Last <b>Keesecker</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1898</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Keesecker</b>				14. MOTHER'S MAIDEN NAME <b>Clara S. Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>March 22, 1960</b> , to <b>June 4, 1960</b> , that I last saw the deceased alive on <b>June 4, 1960</b> , and that death occurred at <b>5:20a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>		DATE SIGNED <b>6-6-60</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		LOCATION (City, town, or county) (State) <b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>6/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catholic</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. [Signature]</b>		ADDRESS <b>1318 Light</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06634

1. NAME OF DECEASED (Type or Print) <b>Mrs. Myrtle Evelyn Kellogg</b>		2. DATE OF DEATH <b>June 26, 1960</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Baltimore County</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore - 6</b> <b>4516 Forest View Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4516 Forest View Avenue</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Feb. 28, 1894</b>
9. AGE (In years last birthday) <b>66</b>		10. UNDER 1 Year Months <b>1</b> Days <b>1</b>	11. UNDER 24 Hours Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Kirby</b>		14. MOTHER'S MAIDEN NAME <b>Rose Ella Mechalske</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>217-01-5318</b>	
17. INFORMANT <b>Mrs. Mildred K. Lupus</b>		ADDRESS <b>same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>420.1 CORONARY Arteriosclerosis with Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arteriosclerosis</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>UPPER RESPIRATORY INFECTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>3 days</b>			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 18 1958</b> to <b>June 26 1960</b> that (I) (we) last saw the deceased alive on <b>June 26 1960</b> and that in (my) (our) opinion death occurred at <b>6:30 p.m.</b> from the causes and on the date stated above.			
23a. SIGNATURE <b>Charles V. Seval</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS <b>5801 Belair Rd.</b>	23c. DATE SIGNED <b>6/27/60</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6/30/60</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25a. DATE REC'D BY HEALTH DEPT. <b>JUL 1 1960</b>		25b. NAME OF REGISTRAR <b>William H. Williams, M.D.</b>	25c. FUNERAL DIRECTOR <b>Leonard J. Ruck 5305 Harford Road.</b>

THIS IS A PERMANENT RECORD  
EVIDENCE OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

AL CERTIFICATION

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Time of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Place of death: \_\_\_\_\_  
10. Signature of attending physician: \_\_\_\_\_  
11. Signature of registrar: \_\_\_\_\_  
12. Signature of informant: \_\_\_\_\_

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH



6676

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Byrl4mth22dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>2636 Loyola Southway</b>	
3. NAME OF DECEASED (Type or print) <b>Dora Kessler</b>		4. DATE OF DEATH Month <b>6</b> - Day <b>8</b> - Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>Joseph Horingier</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records</b>		Address <b>SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident.</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3, 1960</b> to <b>June 8, 1960</b> , that I last saw the deceased alive on <b>June 8, 1960</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6/8/1960</b>	
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>6-9-60</b>	<b>Arzing Reen</b>	<b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Lewis</b>		ADDRESS <b>2100 Eutan Pl</b>	
24a. REC'D BY REGISTRAR <b>JUN 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

UNDERLYING CAUSE

MODE OF DEATH

MODE OF DEATH

PERMANENT DAMAGE

PERMANENT DAMAGE

PREVIOUS ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS SURGERY

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PREVIOUS VALUES

PREVIOUS ATTITUDES

PREVIOUS ATTITUDES

PREVIOUS BEHAVIORS

PREVIOUS BEHAVIORS

PREVIOUS ACTIONS

PREVIOUS ACTIONS

6677

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Indiana</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indianapolis</u> <u>52X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1211 Cobb Road, Pikesville 8, Md.</u>		d. STREET ADDRESS <u>956 Jefferson Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alta</u> Middle <u>Elsie</u> Last <u>Knight</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1900</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jacob Cruser</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Marilyn Allinder, 1211 Cobb Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulm. Edema</u> 692.1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Multiple abscesses (Sepsis)</u> DUE TO (c) <u>3 hrs.</u> 2d.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis - on steroids</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>60</u> , and that death occurred at <u>6</u> <u>PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel Bakal</u>		ADDRESS (Street, city or town, state) <u>3600 Lochearn Dr</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL BAKAL M.D.</u>		DATE SIGNED <u>6-16-60</u>	
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>		22b. DATE THEREOF <u>June 18, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		22d. LOCATION (City, town, or county) (State) <u>Indianapolis, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Newell</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
ADDRESS <u>Indianapolis 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

6633

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15 1920*  
5. Place of birth: *New York City*  
6. Date of death: *Dec 10 1965*  
7. Place of death: *Home*  
8. Cause of death: *Heart Disease*  
9. Signature of physician: *[Signature]*  
10. Signature of registrar: *[Signature]*  
11. Date of registration: *Dec 15 1965*  
12. Place of registration: *New York City*

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Film 207 7-14-60 et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6678**  
**CERTIFICATE OF DEATH**

06637

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>11 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women's &amp; Aged Men's Homes</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nan</u> Middle <u>Lee</u> Last <u>Knight</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1 - 1873</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph R. Knight</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN VAN HORN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Dorance W. Stewart RN,</u> Address <u>615 Chestnut Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Hypertensive pneumonitis, acute congestive</u> DUE TO <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBesity, exogenous</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 19 <u>63</u> , to <u>June 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>60</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Newland Edward Day</u> M.D.				ADDRESS (Street, city or town, state) <u>4-E-33rd St Balto 18md</u> DATE SIGNED <u>7-1-60</u>			
PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S HAMPDEN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK INC. 1217 ST. PAUL ST.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUL 5 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	

CERTIFICATE OF DEATH

6823

Birthplace

Town

Age

Sex

Color

Wife

Married

No

EDWIN VAN HORN

Aug 1 - 1873

Edgewood, N.Y.

Edgewood, N.Y.

Edgewood, N.Y.

Edgewood, N.Y.

Edgewood, N.Y.

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Edgewood, N.Y.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6679

CERTIFICATE OF DEATH

06638

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>22 Maryland Ave.</b>		d. STREET ADDRESS <b>22 Maryland Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>V.</b> Last <b>KREINER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Robert Merrick</b>		14. MOTHER'S MAIDEN NAME <b>Susan Slining</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Dorsey Stewart - 24 Maryland Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma sigmoid colon with generalized metastasis.</b> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as physician) attended the deceased from <b>September 1, 1959</b> to <b>June 20, 1960</b> , that (I) (as last saw the deceased alive on <b>June 19, 1960</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lester Lebo</b>		22b. DATE SIGNED <b>June 21, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>LESTER LEBO, M.D.</b>		22d. ADDRESS <b>1801 Eutaw Place, Baltimore 17, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/22/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Trebner</b>		25a. REC'D BY REGISTRAR <b>June 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1910

06639

## CERTIFICATE OF DEATH

Reg. Dist. No.

6680

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>17 Elinor Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Eva T. Lambden</i> First Middle Last		4. DATE OF DEATH <i>June 18, 1960</i> Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 31, 1897</i>
9. AGE (In years last birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John J. Muller</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Bittner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>214; -14-0485</i>	
17. INFORMANT <i>Mr. Harry Lee Lambden</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thromb &amp; Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>H.A.C.V.D. &amp; Cor. Artry Dis.</i> (b) <i>5+ yr.</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Recent Past history of Congestive Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>June 18, 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 18, 1960</i> to <i>June 18, 1960</i> , that I last saw the deceased alive on <i>June 18, 1960</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik</i> M.D.		ADDRESS (Street, city or town, state) <i>9005 HARFORD BALTO 14 Md.</i> DATE SIGNED <i>6/20/60</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T KASIK</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/21/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 22 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6889

(M)

1. Name of deceased

John J. ...

2. Sex

Male

3. Age

...

4. Date of death

...

5. Place of death

...

6. Cause of death

7. Signature of physician

...

8. Signature of registrar

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Baltimore, Maryland

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06640

6681

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>55</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>923 Southerly Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BELLE</b> Middle <b>MARY</b> Last <b>LANE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1876</b>	9. AGE (In years lost birthday) yrs. <b>83</b>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Buckley Ennis</b>				14. MOTHER'S MAIDEN NAME <b>Emma Lepson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause and line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Meningeal Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Hypertension C-V. Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>	(State) <b>Md.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>6-11-60</b> to <b>6-16-60</b> , that (I) (we) last saw the deceased alive on <b>6-16-60</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James T. Means</b>		22b. DATE <b>June 16, 1960</b>		22c. ADDRESS <b>602 E. Septh Rd. Towson 4, Md.</b>			
22d. PHYSICIAN'S NAME (Type) <b>James T. Means</b>		22e. ADDRESS <b>602 E. Septh Rd. Towson 4, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 20, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	23d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>JUN 20 '60</b>	25b. REGISTRAR'S SIGNATURE <b>James S. Means</b>			

1961

CERTIFICATE OF DEATH

Belmont

Virginia

Belmont

Tolson

Tolson

930 Constitution Ave

930 Constitution Ave

June 16, 1960

June 16, 1960

White

June 22, 1960

X

White

White

White

White

White

White

James T. Tolson

James T. Tolson

Family records

None

None

None

Belmont, Virginia

June 20, 1960 Western Cemetery

June 20, 1960

John Henry Tolson, Jr., Belmont, Virginia



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G265 6-23-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

6682

06641

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Middle River</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1436 Shore Road</b>				d. STREET ADDRESS <b>1436 Shore Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>LANG</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1889</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret-purchasing agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Lang</b>				14. MOTHER'S MAIDEN NAME <b>Mary Schmidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-09-0195</b>		17. INFORMANT Address <b>Lillie M. Kelly, 3846 Elmora Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 yrs</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>60</b> , to <b>6/17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/16</b> , 19 <b>60</b> , and that death occurred at <b>11A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore Md</b> DATE SIGNED <b>6/17/60</b>							
ACTUAL SIGNATURE <b>W B Cunningham</b> M.D.				PHYSICIAN'S NAME (Type) <b>Baltimore Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b> ADDRESS <b>3331 Brehms Lane</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED John Henry Lane		2. SEX Male		3. AGE 70	
4. DATE OF DEATH Nov. 20, 1982		5. PLACE OF DEATH 1130 Shore Road		6. CITY AND COUNTY Baltimore, Md.	
7. DECEASED'S RESIDENCE 1130 Shore Road		8. DECEASED'S OCCUPATION None		9. DECEASED'S MARITAL STATUS Married	
10. DECEASED'S BIRTH DATE Nov. 20, 1912		11. DECEASED'S BIRTH PLACE Baltimore, Md.		12. DECEASED'S RACE White	
13. DECEASED'S RELIGION None		14. DECEASED'S EDUCATION None		15. DECEASED'S SERVICE None	
16. DECEASED'S SOCIAL SECURITY NUMBER None		17. DECEASED'S VETERAN STATUS None		18. DECEASED'S EMPLOYER None	
19. DECEASED'S EMPLOYER ADDRESS None		20. DECEASED'S EMPLOYER PHONE None		21. DECEASED'S EMPLOYER FAX None	
22. DECEASED'S EMPLOYER CITY AND STATE None		23. DECEASED'S EMPLOYER ZIP None		24. DECEASED'S EMPLOYER COUNTRY None	
25. DECEASED'S EMPLOYER TYPE None		26. DECEASED'S EMPLOYER INDUSTRY None		27. DECEASED'S EMPLOYER OCCUPATION None	
28. DECEASED'S EMPLOYER TITLE None		29. DECEASED'S EMPLOYER SALARY None		30. DECEASED'S EMPLOYER BENEFITS None	
31. DECEASED'S EMPLOYER EMPLOYMENT DATE None		32. DECEASED'S EMPLOYER EMPLOYMENT TYPE None		33. DECEASED'S EMPLOYER EMPLOYMENT STATUS None	
34. DECEASED'S EMPLOYER EMPLOYMENT REASON None		35. DECEASED'S EMPLOYER EMPLOYMENT END DATE None		36. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
37. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		38. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		39. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
40. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		41. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		42. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
43. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		44. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		45. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
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55. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		56. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		57. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
58. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		59. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		60. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
61. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		62. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		63. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
64. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		65. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		66. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
67. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		68. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		69. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
70. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		71. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		72. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
73. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		74. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		75. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
76. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		77. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		78. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
79. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		80. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		81. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
82. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		83. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		84. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
85. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		86. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		87. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
88. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		89. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		90. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
91. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		92. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		93. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
94. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		95. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		96. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
97. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		98. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		99. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	
100. DECEASED'S EMPLOYER EMPLOYMENT END TYPE None		101. DECEASED'S EMPLOYER EMPLOYMENT END STATUS None		102. DECEASED'S EMPLOYER EMPLOYMENT END REASON None	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06642

6683

1. PLACE OF DEATH a. COUNTY <b>Rosewood State Training School</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills; Balto Co</b> c. LENGTH OF STAY IN 1b <b>3 yrs. 10 mos.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 284 R.F.D. # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Ford</b> Last <b>Latimer</b>				4. DATE OF DEATH Month <b>6</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1, 1905</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.		IF UNDER 24 HRS. Hours <b>55</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James M. Latimer</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4 91X Acute Bronchopneumonia</b> DUE TO <b>2. Atelectasis of Right lower lobe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Epilepsy</b> DUE TO (c) <b>Meningitis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/3/1960</b> to <b>6/4/1960</b> that (I) (we) last saw the deceased alive on <b>11 p.m. 1960</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John A. Pappas</b>				22b. DATE SIGNED <b>6/4/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. PAPPAS</b>				22d. ADDRESS <b>Univ. Hosp. Baltimore, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-7-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. 517 11<sup>th</sup> St SE Wash DC</b>				25a. REC'D BY REGISTRAR <b>JUN 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

MEDICAL CERTIFICATION

(M)

1943

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06643

6684

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Graceland Park</u>		c. LENGTH OF STAY IN 1b <u>6903 Fait Ave. Balto., 24, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6903 Fait Ave. Balto., 24, Md.</u>		e. STREET ADDRESS <u>6903 Fait Ave. Balto., 24, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>LOTTIE A. LAUTERBACH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>19 60.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec., 5, 1894</u>
9. AGE (in years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
13. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Columbus Keys</u>		16. MOTHER'S MAIDEN NAME <u>Mary Rutter</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>-----</u>	
19. INFORMANT <u>John J. Lauterbach</u>		Address <u>408 Folcroft St. # 24.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-13 -60.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>7225 Eastern Blvd. Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Seiler</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '60</u>	
ADDRESS <u>6224 Eastern Ave. Balto., 24, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH			
JAMES EARL RAY		35		Male		White		April 4, 1968			
PLACE OF BIRTH		CITY		STATE		COUNTRY		DATE OF BIRTH			
Memphis, Tennessee		Memphis		Tennessee		United States of America		January 5, 1933			
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		DATE OF MARRIAGE			
Attorney		High School Graduate		Methodist		Married		November 1955			
PREVIOUS MEDICAL HISTORY		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH			
None		FIRE		Accidental		Hotel Room		April 4, 1968			
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH			
The deceased was found in his hotel room, Room 306, at the Lorraine Hotel, 221 North Second Street, Memphis, Tennessee, on the morning of April 4, 1968. He was found by a hotel maid who reported the discovery to the police. The body was found in a pool of blood on the floor of the room. The deceased was wearing a white shirt and dark trousers. There were no signs of forced entry into the room. The police immediately called the medical examiner to the scene. The medical examiner arrived at approximately 10:00 AM and conducted a preliminary examination of the body. He found no external injuries or signs of trauma. He then transported the body to the medical examiner's office for a post-mortem examination. The post-mortem examination revealed that the deceased had died from a gunshot wound to the chest. The bullet entered the chest from the front and exited the back. There were no other injuries or signs of trauma. The medical examiner determined that the death was accidental and that there were no signs of foul play. He completed the Medical Examiner's Certificate of Death and provided a copy to the police and the family.		The deceased was found in his hotel room, Room 306, at the Lorraine Hotel, 221 North Second Street, Memphis, Tennessee, on the morning of April 4, 1968. He was found by a hotel maid who reported the discovery to the police. The body was found in a pool of blood on the floor of the room. The deceased was wearing a white shirt and dark trousers. There were no signs of forced entry into the room. The police immediately called the medical examiner to the scene. The medical examiner arrived at approximately 10:00 AM and conducted a preliminary examination of the body. He found no external injuries or signs of trauma. He then transported the body to the medical examiner's office for a post-mortem examination. 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after death. Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
06644

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>105 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3401.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1224 NORTH BENTALOU STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VERNON</b> Middle <b>J</b> Last <b>LAWS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 9, 1918</b>	
9. AGE (In years lost birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BELL HOP</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>HERMAN M. LAWS</b>				14. MOTHER'S MAIDEN NAME <b>ELMIRA HALL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-11</b>				16. SOCIAL SECURITY NO. <b>217-26-6020</b>		17. INFORMANT <b>CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> <b>XXXX</b> ASSOCIATED WITH UREMIA AND PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LEENEC'S CIRRHOSIS - Unknown Duration</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <b>BALTIMORE</b> (County) <b>MARYLAND</b> (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 19 1960</b> to <b>June 3 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 3 1960</b> , and that death occurred <b>3:15am</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>C. B. COPE</b>				22b. ADDRESS <b>M.D. VAH BALTIMORE MD-FORT HOWARD DIVISION</b>		22c. DATE SIGNED <b>6-3-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>6-4-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. JOHNSON</b> <b>Samuel H. Johnson, Jr.</b>				24b. ADDRESS <b>1011 N. Arlington Ave</b> <b>Baltimore, Maryland</b>		25a. RECORDING <b>JUN 7 1960</b>	
25b. RECORDING <b>JUN 7 1960</b>				25c. RECORDING <b>JUN 7 1960</b>			

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STATE OF TEXAS

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6686

## CERTIFICATE OF DEATH

06645.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>28yr2mth24dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Christopher</u> Last <u>Lephardt</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>construction work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Christopher Lephardt</u>		14. MOTHER'S MAIDEN NAME <u>Kate Ravine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 8</u> , 19 <u>60</u> , to <u>June 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 22</u> , 19 <u>60</u> , and that death occurred at <u>9:40a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 6-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick A. Cole</u>		ADDRESS <u>1913 N. Balle St.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6687  
CERTIFICATE OF DEATH  
06646

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> M 090 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College manor</u>		d. STREET ADDRESS <u>4403 Bedford Place</u>	
3. NAME OF DECEASED (Type or print) <u>Judge Oscar</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick Leser</u>		14. MOTHER'S MAIDEN NAME <u>Emily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>812-16-2705A</u>	
17. INFORMANT <u>Estella Matthews</u>		Address <u>4403 Bedford Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Arterio-sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of lower mandible</u> DUE TO (c) <u>General arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>June 23, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lee K Fargo</u>		22b. DATE SIGNED <u>6-23-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEE K FARGO</u>		22d. ADDRESS <u>8155 LOCH RAVEN BLVD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>6-25-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN O. MITCHELL &amp; SONS, INC.</u>		24. ADDRESS <u>1900 EUTAW PL.</u>	
25a. REC'D BY REGISTRAR <u>DATE JUN 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6688

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Campus Hill</b>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Squires Rd.</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3701.4		
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>DOLLINGER</b> Last <b>LEUTNER</b>			4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 60</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1889</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Charles Dollinger</b>			14. MOTHER'S MAIDEN NAME <b>Amelia --</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Sophia L. Bortner - 1311 Southview Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation</b> DUE TO <b>Hanging</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Depressed Under Psychiatric Care</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Pikesville, Md.</b>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/23/60</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lickner &amp; Sons - Balt</b>		ADDRESS <b>17 Md</b>		24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles L. S.</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED DOUGLAS		SEX MALE		AGE 35	
DATE OF DEATH JUNE 15, 1964		PLACE OF DEATH HOME		CITY ALBANY	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL HISTORY HYPERTENSION	
DATE OF EXAMINATION JUNE 15, 1964		PLACE OF EXAMINATION HOME		CITY ALBANY	
NAME OF EXAMINER DR. J. J. JONES		SIGNATURE [Signature]		DATE JUNE 15, 1964	
NAME OF DECEASED DOUGLAS		SEX MALE		AGE 35	
DATE OF DEATH JUNE 15, 1964		PLACE OF DEATH HOME		CITY ALBANY	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL HISTORY HYPERTENSION	
DATE OF EXAMINATION JUNE 15, 1964		PLACE OF EXAMINATION HOME		CITY ALBANY	
NAME OF EXAMINER DR. J. J. JONES		SIGNATURE [Signature]		DATE JUNE 15, 1964	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06648

6689

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>3001.4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Lines</i>		d. STREET ADDRESS <i>4506 Bonner Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Lena</i> Middle <i>-</i> Last <i>Levin</i>		4. DATE OF DEATH Month <i>6</i> - Day <i>19</i> - Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>76</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
13. FATHER'S NAME <i>Not Known</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Harry Levin - Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Parkinson's Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-12</i> , 19 <i>58</i> to <i>6-20</i> , 1960 that I last saw the deceased alive on <i>6-7</i> , 19 <i>60</i> , and that death occurred at <i>10:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B Stanley Cohen</i>		ADDRESS (Street, city or town, state) <i>7306 Liberty Rd Balto Md</i>	
PHYSICIAN'S NAME (Type) <i>Lick Levin M</i>		DATE <i>JUN 21 '60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-20-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>United Hebrew</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lick Levin M</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>2100 Eastern Pl</i>		DATE <i>JUN 21 '60</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten notes, possibly a list or ledger, with entries that are mostly illegible due to fading and bleed-through. Some words like "Handwritten" and "List" are visible.

Handwritten notes at the bottom of the page, including a date "1911" and some illegible text.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06649

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>6 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3401.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>1614 HILTON ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DORA</b> Middle <b>B.</b> Last <b>LILLY</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-15-1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>GEORGE HILBERT</b>				14. MOTHER'S MAIDEN NAME <b>MARY CONRADIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT <b>Frank R. Smith Jr. Cockeysville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Qutero Sclerotic Cardio</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>6 years</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/31</b> , 19 <b>54</b> , to <b>6-8</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>6-8</b> , 19 <b>60</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>COCKEYSVILLE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 11, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>				ADDRESS <b>1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUN 13 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Knecht</b>			

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DR. J. W. MOORE

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1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY <b>69X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMILY</b> First <b>A. LINDSAY</b> Middle <b>L</b> Last <b>90</b>		4. DATE OF DEATH <b>JUNE 20 1960</b> Month Day Year	
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-7-1870</b>	
9. AGE (In years last birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
13. FATHER'S NAME <b>CONRAD SCHIRM</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank R. Smith Jr.</b> Address <b>Cockeysville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-1 1960</b> , to <b>6-20 1960</b> , that (I) (we) lost the deceased alive on <b>6-17 1960</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>6/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-22-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUN 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>			

CERTIFICATE OF DEATH

NEW YORK

DEATH NO.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

DATE OF DEATH

TIME

PLACE

DATE OF BIRTH

SEX

AGE

DATE OF DEATH

U.S.

DATE OF BIRTH

DATE OF DEATH

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DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

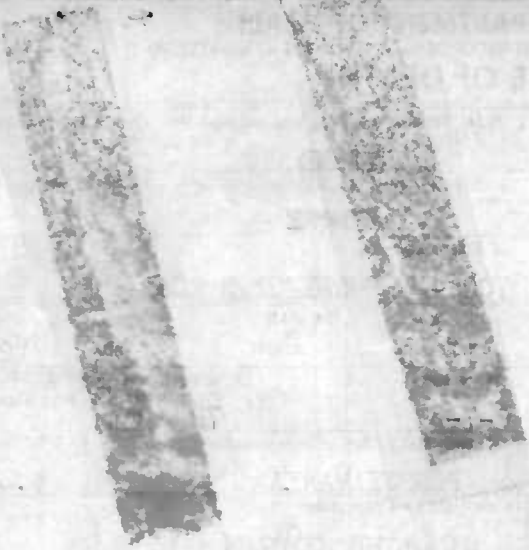
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Shipped to: RICHARD HEROD FUNERAL HOME  
 MORGANTOWN STREET  
 POINT MARION PA

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 6692 CERTIFICATE OF DEATH

06651

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>44 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>E</b> Last <b>LITMAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
13. FATHER'S NAME <b>THOMAS R. LITMAN</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE KEFOVER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>162-14-0025</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG WITH REMOTE METASTASES</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>NEPHROSCLEROSIS, ARTERIOSCLEROTIC</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Encephalomalacia, pons - duration unknown</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>May 8 1960</b> to <b>June 21 1960</b> , that <b>1</b> (we) last saw the deceased alive on <b>June 21 1960</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Clyde B. Cope</b>		22b. DATE SIGNED <b>6-22-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>		22d. ADDRESS <b>VAH BALTIMORE MD - FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>6-24-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>POINT MARION MEMORIAL</b>	23d. LOCATION (City, town, or county) (State) <b>POINT MARION PENNSYLVANIA</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight Inc</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thaw</b>



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# CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Baltimore</b>		c. LENGTH OF STAY IN 1b <b>42 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEL Air R.D.</b>		12x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa</b>		d. STREET ADDRESS <b>Thomas Run Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA W. Lochary</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 12, 1877</b>	
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Harf. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lochary</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mr. John P. Lochary</b>		Address <b>6118 Alta Ave, Baltimore 6, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 1950</b> to <b>6/21</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>6/21</b> , 19 <b>60</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John Russell Davis, M.D.</b>		22b. DATE SIGNED <b>6/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John R. Davis, M.D.</b>		22d. ADDRESS <b>401-02 Medical Arts</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JUNE 23, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hickory, Harf. Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Fater</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 24 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

50000

CERTIFICATE OF DEATH

1913

(1)

John Wilson  
born 1851  
died 1913  
age 62  
cause of death  
heart failure  
place of death  
home  
sex M  
color W  
religion  
education  
occupation  
manner of death  
signature  
date

(2)

John Wilson  
born 1851  
died 1913  
age 62  
cause of death  
heart failure  
place of death  
home  
sex M  
color W  
religion  
education  
occupation  
manner of death  
signature  
date



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G264 6-13-60 et

6694

CERTIFICATE OF DEATH

06653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Barto Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Barto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				e. STREET ADDRESS <u>501 Adana Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anita</u> Middle <u>M.</u> Last <u>Logan</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ronald Munter</u>				14. MOTHER'S MAIDEN NAME <u>Anita Benois</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Ronald A Logan</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-2</u> , 19 <u>60</u> , to <u>6-3</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>6-2</u> , 19 <u>60</u> , and that death occurred at <u>5:50 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Williams</u>				ADDRESS (Street, city or town, state) <u>1632 Pikesville Road</u> DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Williams, M.D.</u>				<u>Pikesville 8, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/7/60</u>		<u>Meadow Bridge</u>		<u>Howard Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macdonald &amp; Son</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

SEX

RACE

EDUCATION

INDUSTRY

RELIGION

PREVAILING DISEASE

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

PLACE OF BIRTH

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of State Health Officer

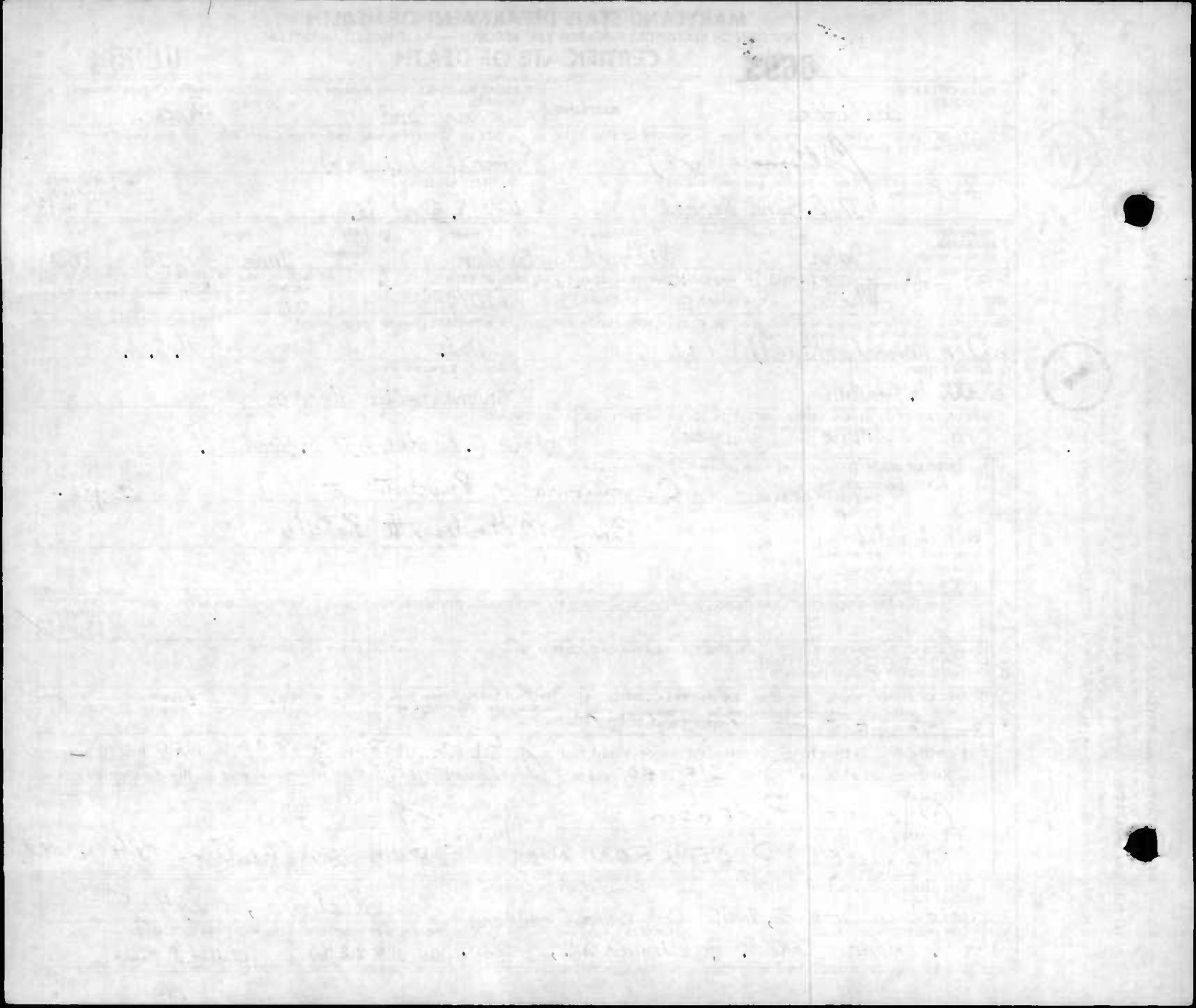
Signature of State Surgeon

Signature of State Auditor

Signature of State Treasurer

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 06654

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prato</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (24)</u>				c. LENGTH OF STAY IN 1b <u>X</u> Rural (Baltimore)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>437 S. 52nd Street</u>				d. STREET ADDRESS <u>437 S. 52nd St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Michael Lorden</u>				4. DATE OF DEATH Month Day Year <u>June 18 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/98</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>		11. BIRTHPLACE (State or foreign country) <u>Del.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>XXXXX B. Lorden</u>				14. MOTHER'S MAIDEN NAME <u>Annastastia Keenan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Elsie M. Lorden</u>		Address <u>437 S. 52nd St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate &amp; Bone Metastases to Pelvis</u> 177X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 12 1959</u> to <u>June 16 1960</u> , that (I) <u>was</u> last saw the deceased alive on <u>June 16 1960</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Manuel P. de Leon</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL P. DE LEON M.D.</u>				22d. ADDRESS <u>7840 Eastern Ave. Balt. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 22, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>				3000 E. Baltimore St., Balto.		25a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			



6696

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4232 Overton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>M.</b> Last <b>Lucy</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1899</b>
9. AGE (In years lost birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Giles R. Cook</b>		14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mr. Raymond F. Lucy</b>		Address <b>4232 Overton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Breast with</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases to bone &amp; lung</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5/56</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>June</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 3</b> , 19 <b>60</b> , and that death occurred at <b>1:30 P.</b> -M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Warfield M. Firoz</b> M.D.			
PHYSICIAN'S NAME (Type) <b>WARFIELD M. FIROZ</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUN 7 1960</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

1

1

IN SENATE,  
January 1, 1903.  
REPORT  
OF THE  
ATTORNEY GENERAL,  
JAMES C. HENRICKS,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 1, 1902.  
ALBANY:  
JAMES C. HENRICKS,  
ATTORNEY GENERAL.  
1903.



## CERTIFICATE OF DEATH

Reg. Dist. No.

6697

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Agneta Lux</b>				4. DATE OF DEATH Month Day Year <b>June 6 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 11, 1878</b>	
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Jacob Lux</b>				14. MOTHER'S MAIDEN NAME <b>Anna Arnold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Sister M. Peter Fourrier Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of uterus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic cancer of lung</b> DUE TO (c) <b>8 mos.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>May 19 1960</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1952</b> to <b>June 6 1960</b> , that I last saw the deceased alive on <b>May 31st. 1960</b> , and that death occurred at <b>6:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>6/6/60</b>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>6-8-60</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Villa Maria Cem. Notch Cliff, Md. Towson, Md.</b>							
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles S. Zeiler 6224 Eastern Ave</b>							
24a. REC'D BY REGISTRAR DATE <b>10 '60</b>							
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MADE IN U.S.A.  
 REGISTERED  
 TRADE MARK  
 PATENTED  
 1910

Name of Deceased _____		Date of Birth _____		Sex _____	
Usual Residence _____		Date of Death _____		Time of Death _____	
Cause of Death _____		Place of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____		Signature of Coroner _____	
Date of Certificate _____		Place of Issuance _____		Office of Registrar _____	

6698

# CERTIFICATE OF DEATH

Reg. Dist. No.

06657

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		/ d. STREET ADDRESS <u>115 Brightside Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Ephraim Mallonee</u>		4. DATE OF DEATH Month Day Year <u>June 13 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tipton Mallonee</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Anne Buckingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Augusta Mallonee</u>		Address <u>Pikesville 8, Md. 115 Brightside Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Art. Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>5 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>June 13<sup>th</sup></u> , 1960, that I last saw the deceased alive on <u>June 12<sup>th</sup></u> , 1960, and that death occurred at <u>4:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>		DATE SIGNED <u>6/14/60</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd. Pikesville - 8, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Howell, Pikesville</u>		ADDRESS <u>1331 Reisterstown Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1900

(M)

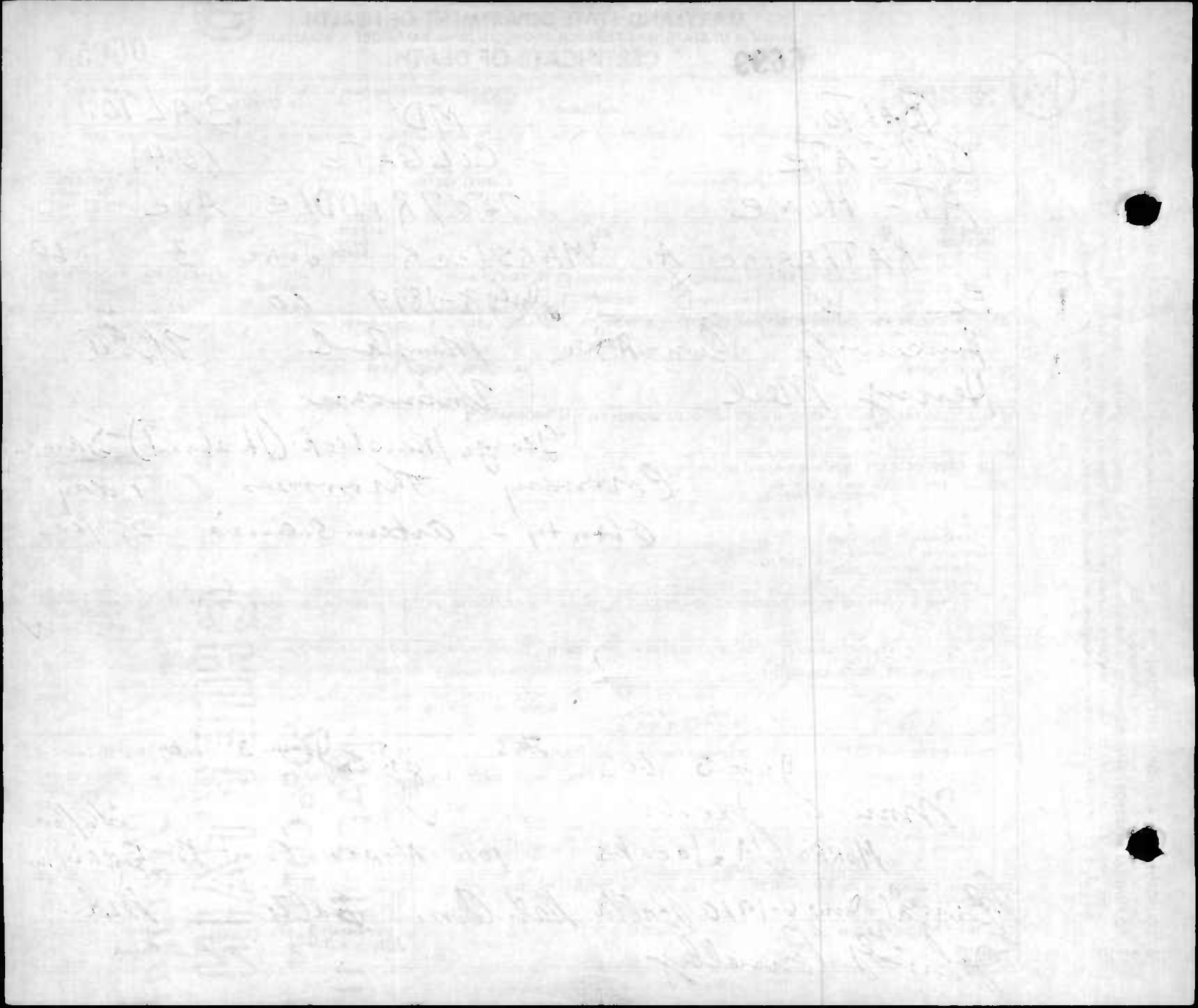
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 6699 CERTIFICATE OF DEATH 06658

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE</u> c. LENGTH OF STAY IN 1b <u>(24)</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE</u> d. STREET ADDRESS <u>17507 RIDDLE Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE A. MARSHACK</u> First Middle Last		4. DATE OF DEATH <u>June 3 1960</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8 - 1899</u> 9. AGE (In years lost birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own - Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Henry Meil</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>George Marshack (Husband)</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Obesity - Arterio Sclerosis</u> DUE TO (c) <u>25 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1955</u> to <u>June 3 1960</u> , that (I) (we) lost saw the deceased alive on <u>June 3 1960</u> , and that death occurred at <u>8:30 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Morris A. Jacobs</u>		22b. DATE SIGNED <u>6/6/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS</u>		22d. ADDRESS <u>1010 NORTH Point Rd BERRYMAN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 6 - 1960</u>		23b. DATE THEREOF <u>June 6 - 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelley</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1960</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	





6700

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN TB <u>55</u> <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1320 Highland DR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Hugh</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 19, 1905</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Harry D. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Emma Robey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Sallie Carolyn Martin 1320 Highland Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>QUOTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>6/4</u> , 1960, that I last saw the deceased alive on <u>6/4</u> , 1960, and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>University Apt, Balt-1 md</u> DATE SIGNED <u>6/5/60</u>			
ACTUAL SIGNATURE <u>Francis J. Borges</u> M.D.		PHYSICIAN'S NAME (Type) <u>FRANCIS J. BORGES, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Reidsville - N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc.</u> ADDRESS <u>5305 Hartford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

**TO HOSPITAL:** **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2700

(M)

(M)



may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
6  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6701  
CERTIFICATE OF DEATH  
06660

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Balt.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1412 Clairidge Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>R.</b> Last <b>Matthews</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1892</b>	
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>11</b> Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Davidson Transf. Md.</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Noah F. Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Alice Tull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>212-09-1528</b>			
17. INFORMANT Address <b>Mrs Nellie Matthews, 1412 Clairidge Rd.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory failure</b> DUE TO <b>dehydration &amp; malnutrition</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Cancer of prostate &amp; spine</b> DUE TO <b>metastases.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>metastases.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 19</b> to <b>11 June 1960</b> that (I) (we) last saw the deceased alive on <b>11 June 1960</b> , and that death occurred at <b>4:15 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William J. Bryson</b> M.D.				22b. DATE SIGNED <b>13 June 60</b>			
22c. PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>				22d. ADDRESS <b>4605 Edmondson Ave</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/14/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>A A Co Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Fun. Dir.</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 16 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>							

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

1011 Clairidge Rd.  
Catoctonville, Md.  
1011 Clairidge Rd.  
Catoctonville, Md.

June 10, 1948  
N. W.  
N. W.

Davidson, James M.  
Nash, E. Matthews  
Alice Paul

1011 Clairidge Rd., Catoctonville, Md.

*[Faint, mostly illegible text, possibly a letter or report body]*

Special Agent in Charge  
U. S. Department of Justice  
Washington, D. C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6702

## CERTIFICATE OF DEATH

Reg. Dist. No.

06661

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>44yrl4mth23dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Rosa</b> Last <b>McCubbin</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Baker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Elliott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>60</b> to <b>June 23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 23</b> , 19 <b>60</b> , and that death occurred at <b>10:30 a</b> . M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-23-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Market Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>New Market, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons - Balt</b>		24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>John S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PRESENT ADDRESS</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. PLACE OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF PHYSICIAN</p> <p>18. SIGNATURE OF REGISTRAR</p> <p>19. SIGNATURE OF WITNESSES</p> <p>20. SIGNATURE OF DECEASED</p>		<p>21. NAME OF PHYSICIAN</p> <p>22. ADDRESS OF PHYSICIAN</p> <p>23. SIGNATURE OF PHYSICIAN</p> <p>24. NAME OF REGISTRAR</p> <p>25. ADDRESS OF REGISTRAR</p> <p>26. SIGNATURE OF REGISTRAR</p> <p>27. NAME OF WITNESSES</p> <p>28. ADDRESS OF WITNESSES</p> <p>29. SIGNATURE OF WITNESSES</p> <p>30. NAME OF DECEASED</p> <p>31. ADDRESS OF DECEASED</p> <p>32. SIGNATURE OF DECEASED</p>
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6703 Item 9 FilmG265 6-22-60 et

Reg. Dist. No. 06662

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River 20</u>		c. LENGTH OF STAY IN lb <u>7 yrs</u> <u>Baltimore</u> <u>34</u> <u>3V01.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>		d. STREET ADDRESS <u>6810 Conley Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAXIE LEE</u> First Middle Last		4. DATE OF DEATH <u>JUNE 18</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1934</u> 9. AGE (In years last birthday) <u>25</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Berlin McDonald</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Allan Messenger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>234-52-8964</u>	
17. INFORMANT <u>Wallace Whetsell</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in Bay's OTS - North Middle River - Not known</u>	
20c. TIME OF INJURY <u>9:15</u> o. m. <u>JUNE 17</u> 19 <u>60</u> Month, Day, Year	20d. INJURY OCCURRED <u>While of work</u> <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Middle River</u>	20f. City or town <u>Bay's OTS - 20 - Baltimore</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		DATE SIGNED <u>6/18/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>6/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenleaf Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Parsons County, W.Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Byrd</u>		24a. REC'D BY REGISTRAR <u>JUN 20 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6704

Items 8, 9, 11 Film G264 6-13-60 et

## CERTIFICATE OF DEATH

06663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3001.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>MERICAN</u> Last <u>AMERICAN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877 SEPT. 18/76</u>
9. AGE (In years lost birthday) <u>82 8/3</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoes</u>	
11. BIRTHPLACE (State or foreign country) <u>PALM BEACH New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>IRVING ROYERS - 3607 LABYRINTH RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Disorganization</u> DUE TO <u>1777X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma of Lung</u> DUE TO <u>2771</u> (c) <u>Carcinoma of Prostate</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>6 wks</u> <u>2771</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18c)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-27-1959</u> to <u>6-2-1960</u> , that I last saw the deceased alive on <u>6-2-1960</u> , and that death occurred at <u>2:57 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. <u>6209 Frederick Ave. 6-2-60</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u> <u>Baltimore-28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-5-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETH TFILOH</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc - 2100 Euterio Place</u>		24a. REC'D BY REGISTRAR <u>JUN 3 '60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, illegible handwriting visible through the paper, likely from the reverse side.]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6705

06664

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>12 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Baltimore</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>								d. STREET ADDRESS <b>5104 St. George Avenue</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b>				Middle <b>J.</b>				Last <b>MERRILL</b>				4. DATE OF DEATH Month <b>June</b>				Day <b>15</b>				Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 1, 1886</b>				9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>7</b>		IF UNDER 24 HRS. Days <b>15</b>		Hours <b>15</b>		Min. <b>4</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Clerk- Unemployed</b>								10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Government</b>				11. BIRTHPLACE (State or foreign country) <b>Hartford, Connecticut</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Samuel D. Merrill</b>								14. MOTHER'S MAIDEN NAME <b>Edith Stetson</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I</b>				17. INFORMANT <b>None</b>				Address <b>Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE AND</b>																<b>UNKNOWN</b>							
420.0 <b>ACUTE HEMORRHAGIC ILEOCOLITIS, NON SPECIFIC</b>																<b>RECENT</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>EMPHYSEMA, MARKED</b>																<b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>June 3</b> <b>6:00</b> to <b>June 15</b> <b>1960</b> , that <del>(he)</del> (we) last saw the deceased alive on <b>June 15</b> <b>1960</b> , and that death occurred at <b>p</b> M., from the causes and on the date stated above.																							
22a. SIGNATURE <b>Clyde B. Cope</b>																M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>6/16/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>																22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/18/60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Son</b>								ADDRESS <b>4905 York Rd. Balto. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 17 '60</b>				25b. REGISTRAR'S SIGNATURE <b>W. A. Frank</b>							

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STATE OF TEXAS  
COUNTY OF DALLAS

1902



(1)

State of Texas, County of Dallas

IN SENATE

February 1, 1902

John A. ...

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6706

## CERTIFICATE OF DEATH

Reg. Dist. No.

06665

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>335 Southeastern Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie E. Miller</b>		4. DATE OF DEATH <b>June 20, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1907</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>52</b> Days <b>20</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob A. Seidel</b>		14. MOTHER'S MAIDEN NAME <b>Harriet M. German</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-10-0769</b>	
INFORMANT <b>Mr. Frederick E. Miller</b>		Address <b>316 Dale Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> 174X DUE TO <b>Carcinoma of Uterus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b> <b>14 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 29, 1960</b> , to <b>June 20, 1960</b> , that I last saw the deceased alive on <b>June 7, 1960</b> , and that death occurred at <b>9:08 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Miceli</b> M.D.		ADDRESS (Street, city or town, state) <b>108 S. Taylor Ave Baltimore 213 Md</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI M.D.</b>		DATE SIGNED <b>6/21/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-24-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lillian Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. R...</b>	

VS A15 (4)  
15M 9/58

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

192



*[Faint, illegible text and lines on a form, likely a death certificate, with a vertical line down the center.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06666

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowlings OTS-70</u>		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Middlebough (21)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NONE</u>			d. STREET ADDRESS <u>2205 Middlebough Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>VERNON</u> First <u>Lee</u> Middle <u>Mitchell</u> Last			4. DATE OF DEATH Month <u>JUNE</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1930</u>	9. AGE (In years last birthday) <u>29</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Auel Mitchell</u>			14. MOTHER'S MAIDEN NAME <u>Carrie Merdith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Korean Action</u>		16. SOCIAL SECURITY NO. <u>226-30-1586</u>		17. INFORMANT <u>Evelyn Mitchell</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming &amp; Drowned - Circumstances Unknown</u>			
20c. TIME OF INJURY Month, Day, Year <u>94</u> <u>6-17</u> <u>1960</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Middlebough</u>	20f. (City or town) <u>Bowlings OTS-70</u>	(County) <u>BALTO.</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/19/60</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bruzdinski</u>			24a. REC'D BY REGISTRAR <u>JUN 20 60</u>		
ADDRESS <u>1407 Eastern Ave.</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>		



# 1 7 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/55 6708 090 M I 0 1 VS A15 (4) 15M 9/55 6708 090 M I 0 1 VS A15 (4) 15M 9/55

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>				d. STREET ADDRESS <i>502 S. Decker Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Vincent</i> Middle <i>J.</i> Last <i>Mone</i>				4. DATE OF DEATH Month <i>June</i> Day <i>16</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25, 1903</i>	9. AGE (In years last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Metal Finisher</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>Salvadore Mone</i>				14. MOTHER'S MAIDEN NAME <i>Concetta Padovana</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT Address <i>Mrs Attilia M. Mone 502 S. Decker Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca. of lung</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>10/13</i> , 19 <i>59</i> to <i>6/16</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>6/12</i> , 19 <i>60</i> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>J. H. Goodman</i> M.D. <i>3400 E Balto St</i> <i>6/17/60</i> PHYSICIAN'S NAME (Type) <i>J H Goodman</i> <i>Baltimore Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/20/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md.</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Balto. St. Balto.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

CERTIFICATE OF DEATH

1502

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. STREET ADDRESS 2100 North Charles St.		12. CITY Baltimore		13. STATE Maryland		14. ZIP CODE 21201		15. COUNTY Baltimore	
16. DATE OF DEATH April 4, 1968		17. TIME OF DEATH 10:00 AM		18. PLACE OF DEATH Room 930, Sheraton Hotel		19. CAUSE OF DEATH Suicide by gunshot		20. MANNER OF DEATH Homicide	
21. MEDICAL HISTORY No known chronic diseases.		22. PRESENT ILLNESS Depression.		23. TREATMENT None.		24. PHYSICIAN'S NAME Dr. J. Edgar Hoover		25. HOSPITAL NAME None.	
26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF WITNESS James Earl Ray		28. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		29. SIGNATURE OF CORONER John P. Quigley		30. SIGNATURE OF REGISTRAR John P. Quigley	



1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

2. The cause of death should be stated in as much detail as possible, and should include the immediate, intermediate, and remote causes.

3. The manner of death should be stated as either natural, accidental, homicidal, suicidal, or undetermined.

4. The physician or coroner who has examined the body of the deceased and has determined the cause and manner of death, is to sign this certificate and to file it in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

5. The Registrar of the State Department of Health, Baltimore, Maryland, is to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

6. The Registrar of the State Department of Health, Baltimore, Maryland, is to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

7. The Registrar of the State Department of Health, Baltimore, Maryland, is to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

8. The Registrar of the State Department of Health, Baltimore, Maryland, is to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

9. The Registrar of the State Department of Health, Baltimore, Maryland, is to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

10. The Registrar of the State Department of Health, Baltimore, Maryland, is to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06668

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>43 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>(16)</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1806 Ashburton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>H.</b> Middle <b>MORPHIS</b> Last		4. DATE OF DEATH Month <b>June 29</b> Day <b>1960</b> Year					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1909</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aide- Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Chapel Hill, N. Carolina</b>			
13. FATHER'S NAME <b>Samuel Morphis</b>		14. MOTHER'S MAIDEN NAME <b>Pattie Craige</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>220-24-6340 Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>157X</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>May 17</b> <b>1960</b> to <b>June 29</b> <b>1960</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>June 29</b> <b>1960</b> , and that death occurred at <b>1:05 P. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clyde B. Cope</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/29/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18 MD, FORT HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/2/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		ADDRESS <b>1808 N. Monroe St., Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 1 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>Wm. S. Thane</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06669

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>MD.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural Garrison</i>				c. LENGTH OF STAY IN 1b <i>29 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto 13</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forlough Nursing Home</i>				d. STREET ADDRESS <i>2640 E Hoffman St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Christine</i> Middle <i>Mueller</i> Last <i>Mueller</i>				4. DATE OF DEATH Month <i>June</i> Day <i>23</i> Year <i>1960</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>28 Nov 1883</i>	
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>6</i> Hours <i>15</i> Min.		IF UNDER 24 HRS. Months <i>7</i> Days <i>6</i> Hours <i>15</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>August BUEHLER</i>				14. MOTHER'S MAIDEN NAME <i>Christine Buehler UNIKENHUN</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>ARS daughter Bradshaw Box 322 Finks Bay</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO <i>191-0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coarctation and anemia</i> DUE TO <i>Ca of bladder &amp; gross metastases</i> (c) <i>—</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>4 months</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Time</i> 19 <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>None</i> (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>May 1960</i> to <i>23 Jun 1960</i> , that (I) (we) last saw the deceased alive on <i>20 Jun 1960</i> , and that death occurred on <i>23 Jun 1960</i> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <i>Irving Scherlis</i>				22b. DATE SIGNED <i>23 Jun 60</i>			
22c. PHYSICIAN'S NAME (Type) <i>IRVING SCHERLIS</i>				22d. ADDRESS <i>2 East Read St Balto 2 MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-27-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DRUID RIDGE</i>		23d. LOCATION (City, town, or county) (State) <i>BALTIMORE MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>WM COOK-TOWSON-YORK RD-TOWSON MD</i>				25a. REC'D BY REGISTRAR <i>NO</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur J. Kenna</i>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6265 6-22-60 et

06671

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesco Park Md. 6</b> c. LENGTH OF STAY IN 1b <b>6</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chesco Pk. 6</b> <b>4 *58** Philadelphia Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesco Park Md. 6</b> d. STREET ADDRESS <b>(Chesco Pk.)</b> <b>4 *58** Philadelphia Road 6</b>			
3. NAME OF DECEASED (Type or print) <b>JEROME (Musil) Musil MUSIAL**</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1960</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Separated</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1898</b>	9. AGE (in years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P.R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>			
13. FATHER'S NAME <b>Joseph Musil</b>			14. MOTHER'S MAIDEN NAME <b>Frances---- Clouspa</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>717-07-8690</b>		17. INFORMANT <b>Mrs. Mary A. Musil, 2434 Fleet St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>1</b> DUE TO (c) <b>1</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b> M.D. EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b> ADDRESS (Street, city, town, or county) DATE SIGNED <b>6/15/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 14/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>				
23. FUNERAL DIRECTOR <b>Philip Herwigson</b>		ADDRESS <b>2024 Orleans St. 31</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		

• **Swc** - in default

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### • Introduction

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6712 CERTIFICATE OF DEATH 06672

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>19 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Vol. 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1102 Walker Avenue</b> <del>80360005500000000000</del>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTHER</b> Middle <b>F.</b> Last <b>NEHRENZ SR.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/11/96</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.		IF UNDER 24 HRS. Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Buffalo, New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Nehrenz</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Soergel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I 212-01-7820</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY INFARCTION</b> DUE TO (b) <b>POLYCYTHEMIA</b> (c) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XXXXX</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 Days</b> <b>Unknown</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <b>1/1</b> (this hospital) attended the deceased from <b>June 1</b> 19 <b>60</b> to <b>June 20</b> 19 <b>60</b> , that <b>1/1</b> (we) last saw the deceased alive on <b>June 20</b> 19 <b>60</b> , and that death occurred at <b>10:15 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>C. B. COPE</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>				22d. ADDRESS <b>VAH, Balto. Md. Ft. Howard, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Funeral Home, Baltimore, Md.</b>				ADDRESS <b>5305 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>JUN 22 60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Carroll B.</b>			

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6713

## CERTIFICATE OF DEATH

06673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Overhill + Frederick Rds.</u>				d. STREET ADDRESS <u>Overhill + Frederick Rds.</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph F. Neville Jr.</u> First Middle Last				4. DATE OF DEATH <u>June 29 - 1960</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-12-1921</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph F. Neville Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Ada B. Gosnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Ada P. Neville - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>auricular fibrillation</u> DUE TO <u>10 days</u> (c) <u>Hypertension</u> DUE TO <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1. 2. 1955</u> to <u>6. 29 1960</u> , that I last saw the deceased alive on <u>6. 29 1960</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E. Urban</u>		M.D. <u>805 Frederick Ave</u>		ADDRESS (Street, city or town, state) <u>Catonsville 28, Md.</u>		DATE SIGNED <u>6. 29. 60</u>	
PHYSICIAN'S NAME (Type) <u>George E. URBAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Wippect - 1300 Eutaw Pl.</u>				24a. REC'D BY REGISTRAR <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6714

## CERTIFICATE OF DEATH

06674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>5 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24, Maryland</b> d. STREET ADDRESS <b>839 South Ellwood Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Kevin</b> First Middle Last 4. DATE OF DEATH <b>6 13 19 60</b> Month Day Year				5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>12/29/52</b> 9. AGE (In years last birthday) <b>7</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>---</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joseph P. Oates</b> 14. MOTHER'S MAIDEN NAME <b>Doris Elizabeth Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>---</b> 16. SOCIAL SECURITY NO. <b>---</b> INFORMANT <b>Rosewood Records</b> Address <b>---</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe brain damage, old</b> <b>355X</b> DUE TO <b>complicated by laryngeal</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>edema with obstruction of air ways</b> DUE TO (c) <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>2:15 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter W. Rieckert</b> M.D. <b>4307 Main Field Ave</b> ADDRESS (Street, city or town, state) <b>Baltimore, Md</b> DATE SIGNED <b>6-13-60</b>				PHYSICIAN'S NAME (Type) <b>Peter W. Rieckert</b> <b>Baltimore, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Catholic Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles D. Zeller</b> ADDRESS <b>6224 Eastern Ave Baltimore 24 Md</b> 24a. REC'D BY REGISTRAR <b>JUN 15 '60</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899

ALBANY:  
J. B. LEECH, PRINTER  
1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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6715  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6715  
CERTIFICATE OF DEATH

06675

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3101.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Convalescent Home</u>				d. STREET ADDRESS <u>3501 St. Paul St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carolyn Egerton Odenheimer</u> First Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Bayard Calvert Egerton</u>				14. MOTHER'S MAIDEN NAME <u>Dorothea Von Bories</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Calvert E. Odenheimer</u>		Address <u>619 Sudbrook Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Liver</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Carcinoma Colon</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>18 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-10-1956</u> to <u>6-23-</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>6-23-</u> 19 <u>60</u> , and that death occurred at <u>6:23 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R. H. Silver</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-23-1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Silver</u>				22d. ADDRESS <u>3105 N. Charles St. 18, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/25/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co. Balto. 12, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	



1  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
6716  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6716  
CERTIFICATE OF DEATH

06676

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>42 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 South Broadway Street (31) 3V01.4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>16 S. Broadway St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANK N. OLDEWURTEL</b> First Middle Last <b>Served As: FRANK N. OLDEWURTAL</b>				4. DATE OF DEATH Month Day Year <b>June 10 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 10, 1891</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Edward G. Oldewurtal</b>				14. MOTHER'S MAIDEN NAME <b>Agnes MN Emmett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin. Records, VAH, Balto. 18, Md., Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PANCREAS WITH WIDE SPREAD METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DOX</b> (c) <b>DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH <b>ABOUT 6 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 29 1960</b> , to <b>June 10 1960</b> , that (I) (we) last saw the deceased alive on <b>June 10 1960</b> , and that death occurred at <b>12:55P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles Allen</b>				22b. DATE SIGNED <b>June 10 1960</b>		22c. PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>				22e. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				25a. REC'D BY REGISTRAR <b>6009 Harford Road, Balto. 14 Md.</b>		25b. REGISTRAR'S SIGNATURE <b>DATE JUN 14 '60</b>	

11007

CERTIFICATE OF MARRIAGE

1716



(3)

IN WITNESS WHEREOF

AS WIT

1716

TO THE HONORABLE

GOVERNOR OF THE STATE OF TEXAS

BY THE HONORABLE

GOVERNOR OF THE STATE OF TEXAS

GOVERNOR OF THE STATE OF TEXAS

GOVERNOR OF THE STATE OF TEXAS

U. S. A.

Testimony

1716

James M. Smith

James M. Smith

U. S. A. 1716

U. S. A. 1716

U. S. A. 1716

U. S. A. 1716

1716

U. S. A. 1716

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U. S. A. 1716

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6717 Items 17, 14 Film 286 1-7-60 et  
**CERTIFICATE OF DEATH**

06677

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>56 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>MARK</b> Last <b>PARMLEY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1901</b>
9. AGE (In years last birthday) yrs. <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>	11. BIRTHPLACE (State or foreign country) <b>Mahanoy City, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles S. Parmley</b>	
14. MOTHER'S MAIDEN NAME <b>Lottie E. Stitzer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>Yes</b> (If yes, give dates of service) <b>WW II</b>	
16. SOCIAL SECURITY NO. <b>199-12-6452</b>		17. INFORMANT <b>Clin. Records, VAH, Baltimore 18, Md. Ft. Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG WITH METASTASIS TO THE PERIBRONCHIAL LYMPH NODES, LIVER, PERIADRENAL TISSUE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA, RIGHT</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Acute hemorrhagic and chronic pancreatitis. 2. Arteriosclerosis, generalized. 3. Benign prostatic hypertrophy.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it (this hospital) attended the deceased from <b>April 25, 1960</b> to <b>June 20, 1960</b> , that (it (we) lost saw the deceased alive on <b>June 20, 1960</b> , and that death occurred at <b>3:05</b> A. M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Clyde B. Cope</b>		22b. DATE SIGNED <b>6/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6-20-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>German Protestant Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mahanoy City, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUN 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

252

RECEIVED JAN 10 1964

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Essex</b>						c. LENGTH OF STAY IN lb <b>54</b> <b>Essex</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>15</b>						d. STREET ADDRESS <b>1</b> <b>Riverdale Apartments</b>					
3. NAME OF DECEASED (Type or print) First <b>ALVA</b> Middle <b>JEAN</b> Last <b>PARRIS</b>						4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1960</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 4-1950</b>		9. AGE (In years last birthday) <b>9</b> yrs.		IF UNDER 1 YEAR Months <b>16</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Detroit, Michigan</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ralph Parris</b>						14. MOTHER'S MAIDEN NAME <b>Fredonia Queen</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b> Address <b>same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNDETERMINED</b> <b>983X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:30 P.</b> p.m. <b>6/10 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) <b>Essex</b>		(County) <b>Baltimore</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Wm. York</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						DATE SIGNED <b>June 16, 1960</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>						22b. DATE THEREOF <b>6-18-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monroe Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Livingston Penn.</b>	
23. FUNERAL DIRECTOR <b>John A. Connolly</b>						ADDRESS <b>418 Eastern Blvd Balto 2)</b>					
24a. REC'D BY REGISTRAR <b>md</b>						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

RECEIVED  
JAN 10 1960

BALTIMORE

6118

BALTIMORE

BALTIMORE

Five Star Apartments

James E. [unclear]  
[unclear] [unclear]

James E. [unclear]  
[unclear] [unclear]

James E. [unclear] 6118 [unclear] [unclear]

June 16, 1960

James E. [unclear]  
[unclear] [unclear]

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06679

6719

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>408 Delaware Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida Goldie</b> Middle <b>Pitts</b> Last				4. DATE OF DEATH Month <b>6</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-21-1892</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stewardess</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Teachers College</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Lewis Pitts</b>				14. MOTHER'S MAIDEN NAME <b>Julia Joyce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-16-9595</b>			
17. INFORMANT <b>Wm. E. Pitts</b>				Address <b>Balto. 14, Md. 3002 Oakcrest Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis - Chronic</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decompensation</b> (c) <b>Coronary Insufficiency</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>5 yrs</b> <b>3 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Longerene of great toe and 2nd toe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6-10-60</b> to <b>6-13-60</b> , that I last saw the deceased alive on <b>6-10-60</b> at <b>2 A.M.</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James G. Siffel</b> M.D.				ADDRESS (Street, city or town, state) <b>Reisterstown Md 6-13-60</b>			
DATE <b>6-13-60</b>				DATE <b>6-13-60</b>			
PHYSICIAN'S NAME (Type) <b>James G. Siffel</b>				PHYSICIAN'S NAME (Type) <b>Reisterstown Md 6-13-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Black Rock Baptist</b>	
22d. LOCATION (City, town, or county) (State) <b>Butler, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Residence

Maryland

Baltimore

Township

20 yrs.

Township

400 Delaware Ave.

400 Delaware Ave.

154 Goldie Pitts

6-10-60

Female White

3-21-1892

68

Stewart's

Teachers College Maryland

U.S.A.

Lewis Pitts

Julia Joyce

Baltimore, Md.

No

217-16-9225

Mr. E. Pitts, 3002 Calver Ave.

Burial 6-13-60 Black Rock Baptist Church, Baltimore, Maryland

Stones funeral service, Township 4, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6596

06680

1. PLACE OF DEATH a. COUNTRY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1106 Vernon Ave</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Arbutus</b> d. STREET ADDRESS <b>1106 Vernon Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pearl A. Plate</b> First Middle Last		4. DATE OF DEATH <b>June 29/60</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1900</b> 9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>---Myers</b>		14. MOTHER'S MAIDEN NAME <b>Julia Schoenfelder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Wm. G. Plate, 1106 Vernon Ave. Arbutus, Md.</b> 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>June 27</b> 19 <b>60</b> , to <b>June 29</b> 19 <b>60</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>June 27</b> 19 <b>60</b> , and that death occurred at <b>1:30</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Pearl Pass</b> 22c. PHYSICIAN'S NAME (Type) <b>I. EARL PASS</b>		22b. DATE SIGNED <b>7-6-60</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>4001 Wickens Ctr</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City, town, or county) <b>Baltimore 29, Md.</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.</b> ADDRESS <b>4101 Edmondson Ave. B</b>		25a. REC'D BY REGISTRAR <b>JUL 5 '60</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
13M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6720

CERTIFICATE OF DEATH

06681

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> <i>Catonville</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>3V01.4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONVILLE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HOUSE IN PINES</i>		d. STREET ADDRESS <i>717 S. Poloman St</i>	
3. NAME OF DECEASED (Bertram) First <i>Bertram</i> Middle <i>Raber</i> Last <i>Raber</i>		4. DATE OF DEATH Month <i>June</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 11 1894</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>8</i> Days <i>5</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steam fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Penna</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Raber</i>		14. MOTHER'S MAIDEN NAME <i>-7</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>1-7</i>	
17. INFORMANT <i>Carl Boering</i>		Address <i>717 S. Poloman St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO (c) <i>157</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture left femur 4/15/60</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Patient stumbled &amp; fell in own yard.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>2</i> p.m. Month <i>4</i> Day <i>15</i> Year <i>1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Baltimore City MD</i>	
21. I certify that I attended the deceased from <i>5-10-1960</i> to <i>6-4-1960</i> , that I last saw the deceased alive on <i>6-3-1960</i> , and that death occurred at <i>8:20 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>6209 Frederick Ave. Md.</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, M.D.</i>		<i>Baltimore-28 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 7/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MD Oliver</i>		22d. LOCATION (City, town, or county) (State) <i>Hanover Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ullrich Funeral Home</i>		ADDRESS <i>4210 Belair Rd</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shephard Pratt Hospital, Charles St.</b>					d. STREET ADDRESS <b>2323 Barclay Street</b>					
3. NAME OF DECEASED (Type or print) <b>CHARLES P. RICHARDSON</b>					4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 26, 1940</b>		9. AGE (In years last birthday) <b>20 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months <b>20</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
13. FATHER'S NAME <b>John J. Richardson Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Helie Mae Moore</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>111-11-1111</b>					
17. INFORMANT <b>Helie Richardson</b>					Address <b>2323 Barclay St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>981X</b> (e), stating the underlying cause last. (c) <b>981X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by special policeman during altercation</b>					
2Dc. TIME OF INJURY Month, Day, Year <b>8:05 p.m. 6/21 1960</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>6/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Ann Arundel County</b>	
23. FUNERAL DIRECTOR <b>Holbert - March</b>					ADDRESS <b>928 E. North Ave</b>		24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

FOR FILE  
RECORDED  
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RECEIVED  
FEB 10 1964

Item 18 Film 265 6-24-60 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6722 CERTIFICATE OF DEATH Reg. Dist. No. 066832											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO CITY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY 3V01.4</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>						d. STREET ADDRESS <b>1239 Cleveland St</b>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARY</b> Middle Last <b>RODENHI</b>						<b>4. DATE OF DEATH</b> Month <b>6</b> Day <b>19</b> Year <b>1960</b>					
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3-12-1887</b>		<b>9. AGE</b> (In years lost birthday) <b>73</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>—</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>BALTIMORE MD</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>FRANK REIMER</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>REGINA RIDER</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>—</b>				<b>INFORMANT</b> <b>Hospital Records, Mt. Wilson State Hospital</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>002X</b> IMMEDIATE CAUSE (a) <b>IMMEDIATE CAUSE (a) IMMEDIATE CAUSE (a)</b> DUE TO <b>Far Advanced Pulmonary Tuberculosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, DIABETES, SEMI-KATY</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>6-14</b> , 19 <b>60</b> , to <b>6-19</b> , 19 <b>60</b> that I last saw the deceased alive on <b>6-19</b> , 19 <b>60</b> , and that death occurred at <b>2:50 p.m.</b> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>Mt. Wilson, Maryland</b> <b>DATE SIGNED</b>											
<b>ACTUAL SIGNATURE</b> <b>William Newcomer</b> <b>M.D.</b>						<b>PHYSICIAN'S NAME (Type)</b> <b>Wm. Newcomer, M.D., Superintendent</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>6/22/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>London Park Cem.</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Balto., Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. J. Pickens &amp; Sons - Balto</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 21 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur J. Kenna</b>			

W

6133

CERTIFICATE OF DEATH

1918

Baltimore County

W. Wilson, Secretary

W. Wilson State Hospital

MARY

FRANK WHITE

WILSON

FRANK KEMER

KEMER KEMER

W. Wilson State Hospital

WILSON

WILSON

1918

WILSON

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06684  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto 7</i>		c. LENGTH OF STAY IN 1b <i>7 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Balto. 7</i>		d. STREET ADDRESS <i>3421 Liberty Garden Rd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3421 Liberty Garden Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>GERTRUDE</i> Middle <i>RYAN</i> Last <i>RYAN</i>				4. DATE OF DEATH Month <i>June</i> Day <i>14</i> Year <i>1960</i>			
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 16, 1878</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Reity</i>				14. MOTHER'S MAIDEN NAME <i>Babette Smorlane</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. <i>none.</i>		17. INFORMANT <i>Eliz Ryan (daughter in law)</i> Address <i>Same.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Blindness</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>none.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none.</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i></i> o. m. <i>none.</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none.</i>		20f. (City or town) (County) (State) <i>Home.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>D.D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-17-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Howard Strong</i>				ADDRESS <i>3207 W. NORTH AVE.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 17 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MINNESOTA STATE DEPARTMENT OF HEALTH - BIRTH RECORD 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX (Male or Female)		AGE (In years and months)	
DATE OF DEATH (Month, day, and year)		PLACE OF DEATH (City, town, or village)		COUNTY (Name of county)	
TIME OF DEATH (Hour and minute)		CAUSE OF DEATH (State in full)		MANNER OF DEATH (Natural, accidental, or suicidal)	
SIGNATURE OF MEDICAL EXAMINER (Print name in full)		SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESSES (If known)	
DATE OF EXAMINATION (Month, day, and year)		TIME OF EXAMINATION (Hour and minute)		PLACE OF EXAMINATION (City, town, or village)	
COUNTY (Name of county)		CITY (Name of city)		TOWN (Name of town)	
VILLAGE (Name of village)		PRESTIGE (Name of prestige)		POST OFFICE (Name of post office)	
SCHOOL (Name of school)		RELIGION (Name of religion)		OCCUPATION (Name of occupation)	
MARITAL STATUS (Single, married, widowed, divorced)		EDUCATION (Name of education)		SOCIAL STATUS (Name of social status)	
RACE (Name of race)		COLOR (Name of color)		COMPLEXION (Name of complexion)	
HAIR (Name of hair)		EYES (Name of eyes)		SKIN (Name of skin)	
BUILD (Name of build)		STATURE (Name of stature)		WEIGHT (Name of weight)	
TEMPERATURE (Name of temperature)		PULSE (Name of pulse)		RESPIRATION (Name of respiration)	
BLOOD PRESSURE (Name of blood pressure)		URINE (Name of urine)		STOOL (Name of stool)	
SWEAT (Name of sweat)		SALIVA (Name of saliva)		TONGUE (Name of tongue)	
THROAT (Name of throat)		CHEST (Name of chest)		ABDOMEN (Name of abdomen)	
PELVIS (Name of pelvis)		LIMBS (Name of limbs)		SKIN (Name of skin)	
NAILS (Name of nails)		TEETH (Name of teeth)		EARS (Name of ears)	
NOSE (Name of nose)		MOUTH (Name of mouth)		PHARYNX (Name of pharynx)	
ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)	
LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)		UTERUS (Name of uterus)	
VAGINA (Name of vagina)		PENIS (Name of penis)		TESTES (Name of testes)	
PROSTATE (Name of prostate)		BLADDER (Name of bladder)		URETERS (Name of ureters)	
KIDNEYS (Name of kidneys)		PANCREAS (Name of pancreas)		LIVER (Name of liver)	
SPLEEN (Name of spleen)		LUNG (Name of lung)		HEART (Name of heart)	
AORTA (Name of aorta)		PULMONARY ARTERY (Name of pulmonary artery)		VENTRICLES (Name of ventricles)	
VALVES (Name of valves)		CORONARY ARTERY (Name of coronary artery)		BRONCHI (Name of bronchi)	
TRACHEA (Name of trachea)		ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)	
SMALL INTESTINE (Name of small intestine)		LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)	
UTERUS (Name of uterus)		VAGINA (Name of vagina)		PENIS (Name of penis)	
TESTES (Name of testes)		PROSTATE (Name of prostate)		BLADDER (Name of bladder)	
URETERS (Name of ureters)		KIDNEYS (Name of kidneys)		PANCREAS (Name of pancreas)	
LIVER (Name of liver)		SPLEEN (Name of spleen)		LUNG (Name of lung)	
HEART (Name of heart)		AORTA (Name of aorta)		PULMONARY ARTERY (Name of pulmonary artery)	
VENTRICLES (Name of ventricles)		VALVES (Name of valves)		CORONARY ARTERY (Name of coronary artery)	
BRONCHI (Name of bronchi)		TRACHEA (Name of trachea)		ESOPHAGUS (Name of esophagus)	
STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)		LARGE INTESTINE (Name of large intestine)	
RECTUM (Name of rectum)		UTERUS (Name of uterus)		VAGINA (Name of vagina)	
PENIS (Name of penis)		TESTES (Name of testes)		PROSTATE (Name of prostate)	
BLADDER (Name of bladder)		URETERS (Name of ureters)		KIDNEYS (Name of kidneys)	
PANCREAS (Name of pancreas)		LIVER (Name of liver)		SPLEEN (Name of spleen)	
LUNG (Name of lung)		HEART (Name of heart)		AORTA (Name of aorta)	
PULMONARY ARTERY (Name of pulmonary artery)		VENTRICLES (Name of ventricles)		VALVES (Name of valves)	
CORONARY ARTERY (Name of coronary artery)		BRONCHI (Name of bronchi)		TRACHEA (Name of trachea)	
ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)	
LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)		UTERUS (Name of uterus)	
VAGINA (Name of vagina)		PENIS (Name of penis)		TESTES (Name of testes)	
PROSTATE (Name of prostate)		BLADDER (Name of bladder)		URETERS (Name of ureters)	
KIDNEYS (Name of kidneys)		PANCREAS (Name of pancreas)		LIVER (Name of liver)	
SPLEEN (Name of spleen)		LUNG (Name of lung)		HEART (Name of heart)	
AORTA (Name of aorta)		PULMONARY ARTERY (Name of pulmonary artery)		VENTRICLES (Name of ventricles)	
VALVES (Name of valves)		CORONARY ARTERY (Name of coronary artery)		BRONCHI (Name of bronchi)	
TRACHEA (Name of trachea)		ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)	
SMALL INTESTINE (Name of small intestine)		LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)	
UTERUS (Name of uterus)		VAGINA (Name of vagina)		PENIS (Name of penis)	
TESTES (Name of testes)		PROSTATE (Name of prostate)		BLADDER (Name of bladder)	
URETERS (Name of ureters)		KIDNEYS (Name of kidneys)		PANCREAS (Name of pancreas)	
LIVER (Name of liver)		SPLEEN (Name of spleen)		LUNG (Name of lung)	
HEART (Name of heart)		AORTA (Name of aorta)		PULMONARY ARTERY (Name of pulmonary artery)	
VENTRICLES (Name of ventricles)		VALVES (Name of valves)		CORONARY ARTERY (Name of coronary artery)	
BRONCHI (Name of bronchi)		TRACHEA (Name of trachea)		ESOPHAGUS (Name of esophagus)	
STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)		LARGE INTESTINE (Name of large intestine)	
RECTUM (Name of rectum)		UTERUS (Name of uterus)		VAGINA (Name of vagina)	
PENIS (Name of penis)		TESTES (Name of testes)		PROSTATE (Name of prostate)	
BLADDER (Name of bladder)		URETERS (Name of ureters)		KIDNEYS (Name of kidneys)	
PANCREAS (Name of pancreas)		LIVER (Name of liver)		SPLEEN (Name of spleen)	
LUNG (Name of lung)		HEART (Name of heart)		AORTA (Name of aorta)	
PULMONARY ARTERY (Name of pulmonary artery)		VENTRICLES (Name of ventricles)		VALVES (Name of valves)	
CORONARY ARTERY (Name of coronary artery)		BRONCHI (Name of bronchi)		TRACHEA (Name of trachea)	
ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)	
LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)		UTERUS (Name of uterus)	
VAGINA (Name of vagina)		PENIS (Name of penis)		TESTES (Name of testes)	
PROSTATE (Name of prostate)		BLADDER (Name of bladder)		URETERS (Name of ureters)	
KIDNEYS (Name of kidneys)		PANCREAS (Name of pancreas)		LIVER (Name of liver)	
SPLEEN (Name of spleen)		LUNG (Name of lung)		HEART (Name of heart)	
AORTA (Name of aorta)		PULMONARY ARTERY (Name of pulmonary artery)		VENTRICLES (Name of ventricles)	
VALVES (Name of valves)		CORONARY ARTERY (Name of coronary artery)		BRONCHI (Name of bronchi)	
TRACHEA (Name of trachea)		ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)	
SMALL INTESTINE (Name of small intestine)		LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)	
UTERUS (Name of uterus)		VAGINA (Name of vagina)		PENIS (Name of penis)	
TESTES (Name of testes)		PROSTATE (Name of prostate)		BLADDER (Name of bladder)	
URETERS (Name of ureters)		KIDNEYS (Name of kidneys)		PANCREAS (Name of pancreas)	
LIVER (Name of liver)		SPLEEN (Name of spleen)		LUNG (Name of lung)	
HEART (Name of heart)		AORTA (Name of aorta)		PULMONARY ARTERY (Name of pulmonary artery)	
VENTRICLES (Name of ventricles)		VALVES (Name of valves)		CORONARY ARTERY (Name of coronary artery)	
BRONCHI (Name of bronchi)		TRACHEA (Name of trachea)		ESOPHAGUS (Name of esophagus)	
STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)		LARGE INTESTINE (Name of large intestine)	
RECTUM (Name of rectum)		UTERUS (Name of uterus)		VAGINA (Name of vagina)	
PENIS (Name of penis)		TESTES (Name of testes)		PROSTATE (Name of prostate)	
BLADDER (Name of bladder)		URETERS (Name of ureters)		KIDNEYS (Name of kidneys)	
PANCREAS (Name of pancreas)		LIVER (Name of liver)		SPLEEN (Name of spleen)	
LUNG (Name of lung)		HEART (Name of heart)		AORTA (Name of aorta)	
PULMONARY ARTERY (Name of pulmonary artery)		VENTRICLES (Name of ventricles)		VALVES (Name of valves)	
CORONARY ARTERY (Name of coronary artery)		BRONCHI (Name of bronchi)		TRACHEA (Name of trachea)	
ESOPHAGUS (Name of esophagus)		STOMACH (Name of stomach)		SMALL INTESTINE (Name of small intestine)	
LARGE INTESTINE (Name of large intestine)		RECTUM (Name of rectum)		UTERUS (Name of uterus)	
VAGINA (Name of vagina)		PENIS (Name of penis)		TESTES (Name of testes)	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, institution, and before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6421 Rosemont Ave.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen arm</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wagon Wheel Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS FRANCIS RYAN</b>				4. DATE OF DEATH <b>June 27 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 12, 1892</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		9. AGE (In years last birthday) <b>67</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
13. FATHER'S NAME <b>William Ryan</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. Hanson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-22-1074</b>		17. INFORMANT <b>Mrs. Ruth N. Ryan</b> Address <b>6421 Rosemont Ave. 6</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-30-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jerusalem Lutheran</b>	
23. FUNERAL DIRECTOR <b>Kassahn Funeral Home</b>				22d. LOCATION (City, town, or country) (State) <b>4600 Belair Rd. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '60</b>	
ADDRESS <b>7401 Belair Rd</b>				24b. REGISTRAR'S SIGNATURE <b>Charles L. Evans</b>			

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June 28, 1920

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6725

## CERTIFICATE OF DEATH

06686  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Datonville</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5625 Edmondson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>SALCHUNAS</u> Middle <u>J</u> Last <u>Salchunas</u>		4. DATE OF DEATH <u>June 7</u> Month <u>June</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alterations</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Salchunas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kolitas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-26-2719</u>	
17. INFORMANT <u>Theresa Salchunas</u> Address <u>5625 Edmondson Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>54</u> , to <u>June 7</u> , 19 <u>60</u> . That I last saw the deceased alive on <u>June 6</u> , 19 <u>60</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo J. Gaver</u> M.D.		ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave.,</u> DATE SIGNED <u>6/7/60</u>	
PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>		<u>Baltimore 29, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Geyfel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1915

EXAMINED FROM

Name of deceased		Sex		Age		Date of death	
Place of birth		Place of death		Cause of death		Disease	
Occupation		Signature of physician		Signature of registrar		Signature of informant	
Manner of death		Date of burial		Place of burial		Burial certificate	
Remarks		Remarks		Remarks		Remarks	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06687**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN 1b <b>54</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>311 George Ave.</b>		d. STREET ADDRESS <b>311 George Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>MARGARET SCHIESSER</b>		4. DATE OF DEATH <b>June 21, 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dietz</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hartman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elizabeth Llufo</b>		Address <b>631 N. Stuart Ave. #21</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial Insuff</b> (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack Collins</b>		DATE SIGNED <b>6-21-60</b>	
EXAMINER'S NAME (Type) <b>JACK E COLLINS</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/24/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Bruzdinski</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
ADDRESS <b>1407 Eastern Ave.</b>		DATE <b>JUN 22 '60</b>	

100

# Item 1 Film 6267 7-14-60 et

6727

## CERTIFICATE OF DEATH

06688  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7Ys. 9Mos. 7Dys.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1816 Linden Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Beatrice</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>artist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George E. Schillinger</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Shermer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 18</b> 19 <b>52</b> , to <b>June 24</b> 19 <b>60</b> , that I last saw the deceased alive on <b>June 24</b> 19 <b>60</b> , and that death occurred at <b>11:05a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-24-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McNabb &amp; Son Co.</b>		ADDRESS <b>Co.</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06689

Reg. Dist. No.

6732

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLEIGH</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLEIGH</b>	
c. LENGTH OF STAY IN b. <b>3 years</b>		d. STREET ADDRESS <b>17708 OAKLEIGH RD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7708 OAKLEIGH RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>O.</b> Last <b>Schlee</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 19 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Schmidt</b>		14. MOTHER'S MAIDEN NAME <b>- - - - -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>John W. Schlee</b>		Address <b>3054 Woodside Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42001 Congestive heart failure</b> DUE TO (b) <b>Pulmonary fibrosis c. Cor pulmonale</b> DUE TO (c) <b>Coronary Artery disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia + hypotension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED <b>White</b> <input checked="" type="checkbox"/> <b>Not white</b> <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 5</b> , 19 <b>59</b> , to <b>June</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 19</b> , 19 <b>60</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank T. Kasik</b>		ADDRESS (Street, city or town, state) <b>9005 HARTFORD RD</b>	
PHYSICIAN'S NAME (Type) <b>FRANK T. KASIK</b>		DATE SIGNED <b>BALTIMORE MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/23/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS F. EVANS &amp; SON</b>		ADDRESS <b>8802 HARTFORD RD</b>	
24a. REC'D BY REGISTRAR <b>JUN 28 60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE DEPARTMENT OF HEALTH—BALTIMORE 12



1992



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06690

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb <b>55</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		d. STREET ADDRESS <b>318 Worthington Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>318 Worthington Road</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM A. SCHMIDT</b>				4. DATE OF DEATH Month Day Year <b>June 13 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1947</b>		9. AGE (In years last birthday) <b>13</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pupil</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William A. Schmidt</b>				14. MOTHER'S MAIDEN NAME <b>Jeanette Foote</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Jeanette F. Schmidt</b> Address <b>318 Worthington Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Chest.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>919.0</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Accidentally shot</b>					
20c. TIME OF INJURY Hour <b>3:00</b> p.m. Month, Day, Year <b>6/13 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Towson Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Belair, Md.</b>	
23. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>JUN 15 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>			



TAI  
11

6782

Bellevue

Town

210 Worthington Road

WILLIAM A.

SCOTT

June

210 Worthington Road

White

1909

School

Bellevue

Bellevue A. School

Bellevue A. School

General Fund of State

Accident

6/15/00

June

Town

Bellevue

Charles S. Ford, Jr.

Bellevue

JUN 18 00

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

## CERTIFICATE OF DEATH

06691  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7402 York Rd.</b>		d. STREET ADDRESS <b>7402 York Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>MINNIE FLORENCE MEISNER SCHUTZ</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14. 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Meisner</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Luthold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Elva D. Cruse, Kingsville. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 13</b> 19 <b>60</b> , to <b>June 27</b> 19 <b>60</b> , that I last saw the deceased alive on <b>June 27</b> 19 <b>60</b> , and that death occurred at <b>11 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. J. Schmitz</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>701 N. Fenwick Ave 6/30/60</b>	
PHYSICIAN'S NAME (Type) <b>Wm. J. Schmitz</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1. 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06692

6599

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1225 Dalton Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>Serio</u> Last <u>Serio</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-1895</u>
9. AGE (In years lost birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife-Tailoring</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Salvatori Sarullo</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217189535</u>	
INFORMANT <u>Mrs Marie Cabinet</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Coronary Arterio Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19</u> , 19 <u>59</u> , to <u>6/5/60</u> , 19____, that I last saw the deceased alive on <u>5/17/60</u> , 19____, and that death occurred at <u>64</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm Conway</u> M.D.		ADDRESS (Street, city or town, state) <u>8358 Lock Raven Blvd</u> DATE SIGNED <u>6/6/60</u>	
PHYSICIAN'S NAME (Type) <u>W.M. Conway MD</u>		<u>Towson &amp; Ltd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

CERTIFICATE OF DEATH

1599

WILLIAM H. HARRIS

WILLIAM H. HARRIS

WILLIAM H. HARRIS

WILLIAM H. HARRIS

WILLIAM H. HARRIS

WILLIAM H. HARRIS

WILLIAM H. HARRIS



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6265 6-20-60 et

6590

## CERTIFICATE OF DEATH

Reg. Dist. No.

06693

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>53 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6735 Roberts Avenue</b>				d. STREET ADDRESS <b>6735 Roberts Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Julyan</b> Last <b>Shaduk</b>				4. DATE OF DEATH Month <b>6</b> - Day <b>10</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Shaduk</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs Anna Shaduk 6735 Roberts Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arterio Sclerotic C. V DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , to <b>June 10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>MAY</b> , 19 <b>60</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen P. Mackowiak</b> M.D.				ADDRESS (Street, city or town, state) <b>6714 Holabird Ave</b>		DATE SIGNED <b>6-10-60</b>	
PHYSICIAN'S NAME (Type) <b>J. P. MACKOWIAK</b>				<b>6714 HOLABIRD AV</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski</b>				ADDRESS <b>1001 Dundalk Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06694

6730

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>401 VogTs Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DORIS</u> First <u>L</u> Middle <u>SHAPIRO</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 14, 1918</u>
9. AGE (In years lost birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK P HEINEMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET T SHAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-057057</u>	
17. INFORMANT <u>EMANUEL G SHAPIRO</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENO-CARCINOMA OF RECTUM</u> DUE TO <u>10 MO.</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 1, 1947</u> , to <u>JUNE 2, 1960</u> , that I last saw the deceased alive on <u>JUNE 1</u> , 19 <u>60</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u>		ADDRESS (Street, city or town, state) <u>108 S. TAYLOR AVE</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>		DATE SIGNED <u>6/3/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LEWIS PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS &amp; Son</u>		ADDRESS <u>8808 HARTFORD RD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6731

CERTIFICATE OF DEATH

06695

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 August Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>VIRGINIA</b> Last <b>SINCLAIR</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Haddaway</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Fox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Jane Musacchio - 4 August Ave., Catonsville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 443X DUE TO <b>Advanced Hypertensive &amp; arteriosclerotic</b> (b) <b>cardio-vascular disease.</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3-4 mo (years)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3 Feb 1956</b> to <b>11 June 1960</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9 June 1960</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Emil H. Henning Jr</b> M.D.		22b. DATE SIGNED <b>13 June 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>EMIL H HENNING JR MD</b>		22d. ADDRESS <b>601 WINANS WAY, BALTO 29 MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor &amp; Sons - Balto 7</b>		25a. REC'D BY REGISTRAR DATE <b>11-11-60</b>	
25b. REGISTRAR'S SIGNATURE <b>Emil H. Henning</b>			

UNITED STATES DEPARTMENT OF HEALTH  
CENTRAL RECORDS SECTION

1931



[Faint, mostly illegible text and markings covering the main body of the page, possibly representing a ledger or record sheet.]



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 6591 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66696

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Dundalk		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2804 Creston Road			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH	
WILLIAM D. SMITH				Month Day Year	
June 10 1960					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Oct. 15, 1905		54		Months Days	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Rennert, N. C.		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John C. Smith		Sarah Bowen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		---		Lillian C. Smith Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Shotgun Wound of Chest.			
976X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
		Shot self in chest.			
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		(City or town) (County) (State)	
1:00 p.m. 6/10/60				Home Dundalk Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/11/60	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Charles S. Petty, M.D.		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		6-14-60.		Oak Lawn Cem.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Charles S. Petty		JUN 15 '60		Charles S. Petty	



## 06697

6502

**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 10/57



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6733

## CERTIFICATE OF DEATH

Reg. Dist. No.

06698

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7 W Elm Ave</u>		d. STREET ADDRESS <u>17 W. Elm Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Sophia</u> *First Middle Last		4. DATE OF DEATH <u>June 2</u> 19 <u>60</u> Month Day Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 1885</u> 9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Adam Haber Korn</u>		14. MOTHER'S MAIDEN NAME <u>Anna Theresa Schreiber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles H. Spahn</u> Address <u>7 W. Elm Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma right Kidney</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>180X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>60</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6014 Loch Raven Blvd., Balto. 12, Md</u> DATE SIGNED <u>6-3-60</u>			
ACTUAL SIGNATURE <u>J. F. Palmisano</u>		M.D. <u>6014 Loch Raven Blvd., Balto. 12, Md</u>	
PHYSICIAN'S NAME (Type) <u>J. F. Palmisano, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 6 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM</u>	22d. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shippel Bros</u> ADDRESS <u>7110 BELAIR RD</u>		24a. REC'D BY REGISTRAR <u>JUN 6 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06699

6734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. 6</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. 6</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8927 Philadelphia Road</b>			d. STREET ADDRESS <b>8927 Philadelphia Road</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>W.</b> Last <b>STANLEY, Sr.</b>			4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1960</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1900</b>		9. AGE (In years last birthday) <b>59 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glenn L. Martin Co Md.</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>James W. Stanley</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hamberger</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>World War I 213-05-3284</b>		17. INFORMANT <b>Mr. J. W. Stanley - 8927 Philadelphia Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>1960</b> , that (I) (we) last saw the deceased alive on <b>June 4, 1960</b> , and that death occurred at <b>1100</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>William J. Pickner</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>William J. Pickner</b>		22d. ADDRESS <b>8100 Harford Rd., Balto. 14 Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/25/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louyon Park Cem.</b>	
23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons - Balto. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 24 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6735 CERTIFICATE OF DEATH 06700

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stoneleigh</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>601 Stoneleigh Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Berta</b> Middle <b>D.</b> Last <b>Steffens</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hochneukirch Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bernhard Deussen</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Esser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carl W. Steffens</b>		Address <b>601 Stoneleigh Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> <b>44-3X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 8 1951</b> to <b>June 18 1960</b> , that (I) (we) last saw the deceased alive on <b>June 18 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Laurence C. Post</b>		22b. DATE SIGNED <b>6/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		22d. ADDRESS <b>6805 York Rd. - Baltimore 12 Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation June 21, 60</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>JUN 22 '60</b>	
ADDRESS <b>4905 York Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

CERTIFICATE OF DEATH

1932

(M)

Residence

Occupation

30 yrs.

Not a resident of

22 years

1000 10 1930

Married

Not married

(1)

*Handwritten signature and text, mostly illegible due to fading.*

*Handwritten text at the bottom of the page, including what appears to be a date and possibly a name.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6736

CERTIFICATE OF DEATH

06701

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>29 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3524 Essex Road (7)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARUNAH</b> Middle <b>B.</b> Last <b>STEINFELT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oil Burner Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Service</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charlie Steinfeldt</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Callahan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS of UNKNOWN PRIMARY SITE</b> DUE TO <b>199-2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>199-2</b> DUE TO (b) <b>199-2</b> DUE TO (c) <b>199-2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 4</b> <b>1960</b> to <b>June 2</b> <b>1960</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 2</b> <b>1960</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Clyde B. Coe</b>		22b. DATE SIGNED <b>6/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COE, M.D.</b>		22d. ADDRESS <b>BALTIMORE 18, MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-6-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 6 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

(M)

(1)

333

CERTIFICATE OF DEATH

(1)

DEATH OF MR. JOHN HENRY BROWN

JOHN HENRY BROWN

JOHN HENRY BROWN, 6000 BELLEVUE ST., BOSTON, MASS.

JOHN HENRY BROWN, 6000 BELLEVUE ST., BOSTON, MASS.

JOHN HENRY BROWN, 6000 BELLEVUE ST., BOSTON, MASS.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06702  
6737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9117 Old Harford Rd</u>		d. STREET ADDRESS <u>9117 Old Harford</u>	
3. NAME OF DECEASED (Type or print) <u>James Bernard STENGER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 1878</u> yrs. <u>81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drum Major</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John D. Stenger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Doberneck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42201</u> DUE TO <u>Coronary Occlusion &amp; Myocardial degen. &amp; failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-2-60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Balto</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemard Kruck</u>		ADDRESS <u>5305 Harford</u>	
24a. REC'D BY REGISTRAR <u>JUL 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06703

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>3 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> d. STREET ADDRESS <b>224 South Bruce Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Anthony</b> Last <b>Stickel</b>			4. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/59</b>	9. AGE (In years last birthday) yrs. <b>10</b> Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	
13. FATHER'S NAME <b>Joseph Grant Stickel</b>			14. MOTHER'S MAIDEN NAME <b>Lillian May Thomas</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Rosewood Records</b> Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>325.4</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Heart Disease</b> DUE TO (c) <b>Mongolism</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Birth</b> <b>Birth</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3/17/60</b> to <b>6/21/60</b> , that (I) (we) lost saw the deceased alive on <b>8/21/60</b> , and that death occurred at <b>11:45 am</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward J. Mathews</b>		22b. DATE SIGNED <b>6/21/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward J. Mathews</b>	
22d. ADDRESS <b>Owings Mills, Md.</b>		22e. ADDRESS <b>Rosewood State Training School Box 188</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-24-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>	
23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Geo P. Dehrach</b> ADDRESS <b>2101 Frederick Ave</b>			
25a. REC'D BY REGISTRAR <b>JUN 22 00</b>		25b. REGISTRAR'S SIGNATURE <b>---</b>			

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956

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Baltimore</b> b. COUNTY <b>Essex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Nicholas Chd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>L</b> Last <b>Stolte</b>		4. DATE OF DEATH Month <b>6</b> - Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
13. FATHER'S NAME <b>Harry</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		17. INFORMANT Address <b>Charles F Stolte 365 Nicholson Rd 22</b>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Rheumatoid Arthritis</b> DUE TO <b>Rheumatoid Arthritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>12 years</b> <b>12 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 23, 1957</b> to <b>June 28, 1960</b> , that I last saw the deceased alive on <b>June 28, 1960</b> , and that death occurred at <b>7 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry B. Smith</b>		ADDRESS (Street, city or town, state) <b>413 Eastern Avenue, Balt. 21</b>	
PHYSICIAN'S NAME (Type) <b>Harry B. Smith, M.D.</b>		DATE SIGNED <b>6/30/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski 1008 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR <b>JUL 1 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6740

## CERTIFICATE OF DEATH

Reg. Dist. No. 06705

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7310 Seven Mile Lane</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i> d. STREET ADDRESS <i>7310 Seven Mile Lane</i>	
3. NAME OF DECEASED (Type or print) First <i>Dora</i> Middle <i>Weinman</i> Last <i>Stone</i>		4. DATE OF DEATH Month <i>June</i> Day <i>20</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 12, 1890</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Moses Chaim Weinman</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Pollack</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lympho sarcoma</i> 200-1 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-1</i> , 19 <i>59</i> , to <i>6-20</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>6-20</i> , 19 <i>60</i> , and that death occurred at <i>8:10</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2108 Euterio Place</i> DATE SIGNED <i>June 20, 1960</i> ACTUAL SIGNATURE <i>Shorton M. Kueger</i> M.D. PHYSICIAN'S NAME (Type) <i>Baltimore 17, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 21/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hazton Tereh Is.</i>		22d. LOCATION (City, town, or county) (State) <i>Rosedale, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Soldenman &amp; Sons</i> ADDRESS <i>-6010 Reisterstown Rd</i>		24a. REC'D BY REGISTRAR <i>JUN 24 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>William S. Knead</i>			

CERTIFICATE OF DEATH

1920

(14)

(2)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6741

CERTIFICATE OF DEATH

06706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3017 Oakfordst Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Josef</u> First Middle Last <u>Svoboda</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12th</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Svoboda</u>		14. MOTHER'S MAIDEN NAME <u>Marianna Tomejl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>326-05-6485A</u>	
17. INFORMANT Address <u>Mr. Joseph Svoboda, Jr. same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442 X</u> <u>Arteriosclerotic cardio-vascular</u> <u>rural disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3.5 years</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>2-24</u> , 19 <u>60</u> , to <u>6-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-15</u> , 19 <u>60</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>C. W. Peake</u> M.D. <u>4508 Harford Rd</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6-13-60</u>	
PHYSICIAN'S NAME (Type) <u>C. W. PEAKE</u>		22a. REC'D BY REGISTRAR DATE <u>JUN 15 '60</u>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22c. DATE THEREOF <u>6/15/60</u>	
22d. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22e. LOCATION (City, town, or county) (State) <u>Forest Park, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		23a. ADDRESS <u>5305 Harford Road # 14</u>	
23b. REGISTRAR'S SIGNATURE <u>Arthur S. Pease</u>		23c. DATE <u>JUN 15 '60</u>	

CERTIFICATE OF DEATH

1921

Decedent

(Last name)

First name

Residence

Residence

2017 West Avenue, Portland, Me

2017 West Avenue, Portland, Me

June 17, 1921

June 17, 1921

Age 77

Age 77

(Cause of death)

(Cause of death)

Heart failure

Heart failure

Physician, Dr. J. J. ...

Physician, Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

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Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

Dr. J. J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6742

## CERTIFICATE OF DEATH

Reg. Dist. No.

06707

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>24yrlmth25dys</b> X <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LeRoy</b> Middle <b>Talbert</b> Last <b>Talbert</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Talbert</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Weiland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>490X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5</b> , 19 <b>60</b> , to <b>June 3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 3</b> , 19 <b>60</b> , and that death occurred at <b>12:30</b> <sup>a.m.</sup> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-3-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVE</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Standley</b>		ADDRESS <b>BALTO. MD</b>	
24a. REC'D BY REGISTRAR <b>JUN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kneass</b>	

CERTIFICATE OF DEATH

1923

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES H. HARRIS		Male		45		Jan 15, 1878		Maryland		Farmer	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
Jan 20, 1923		10:30 AM		Home		Heart Disease		Natural		J. H. Harris	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CLERK		16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING.



TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 9/59

1

6597

CERTIFICATE OF DEATH

06708

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u>		c. LENGTH OF STAY IN 1b <u>15 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 HALETHORPE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5629 Ashbourne Rd.</u>				d. STREET ADDRESS <u>15629 Ashbourne Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>August Frederick Taryn</u>				4. DATE OF DEATH Month Day Year <u>June 17, 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1899</u>		9. AGE (In years lost birthday) <u>60 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY TARYN</u>				14. MOTHER'S MAIDEN NAME <u>MARY JUNG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>LENA E. TARYN 5629 Ashbourne Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>9 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis &amp; Cerebral Infarction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> 19 <u>59</u> to <u>6/17</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> 19 <u>59</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Eliot W. Johnson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/18/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eliot W. Johnson</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-21-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. L. Schwab Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>2101 Frederick Ave.</u>				DATE <u>JUN 21 '60</u>			

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

6593

10330

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06709

6743

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>as</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>in</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1015 Riverdrive Rd</u>		d. STREET ADDRESS <u>#1</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE CHRISTINE TAYLOR</u>		4. DATE OF DEATH <u>JUNE 2, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Urbach</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Ewig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-22-9654</u>	
17. INFORMANT <u>MELVIN TAYLOR</u> Address <u>AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition + Dehydration</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Bronchus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1954</u> to <u>June 2, 1960</u> , that I last saw the deceased alive on <u>June 1, 1960</u> , and that death occurred at <u>6:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6908 N. Point Rd</u> DATE SIGNED <u>6/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Tollin M.D.</u>		<u>Balto. 19. Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u> ADDRESS <u>7922 Wise Ave. 22, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christina S. Hume</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6593  
CERTIFICATE OF DEATH

Reg. Dist. No. 06710

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>12 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2529 Liberty Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>C.</b> Last <b>THOMPSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8th</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1880</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Granville T. Currier</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mary E. Thompson</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension + a-s-c-v Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5</b> , 19 <b>60</b> , to <b>June 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 7</b> , 19 <b>60</b> , and that death occurred at <b>3:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6800 Morningson Road</b> DATE SIGNED <b>6/8/60</b> ACTUAL SIGNATURE <b>Melvin B. Davis</b> M.D. <b>Baltimore 22, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Brooks Bradley, Inc.</b>		ADDRESS <b>Dundalk 22</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED Mary Ann Moore		2. SEX Female		3. AGE 40		4. DATE OF BIRTH June 1, 1880		5. PLACE OF BIRTH Maryland		6. US CITIZENSHIP U.S.A.	
7. MARITAL STATUS Married		8. OCCUPATION None		9. CAUSE OF DEATH None		10. PLACE OF DEATH None		11. DATE OF DEATH None		12. SIGNATURE OF DECEASED None	
13. NAME OF PHYSICIAN Dr. J. H. Moore		14. NAME OF SURGEON Dr. J. H. Moore		15. NAME OF PATHOLOGIST Dr. J. H. Moore		16. NAME OF CORONER Dr. J. H. Moore		17. NAME OF JURY Dr. J. H. Moore		18. NAME OF WITNESSES Dr. J. H. Moore	
19. NAME OF FUNERAL HOME Dr. J. H. Moore		20. NAME OF BURIAL PLACE Dr. J. H. Moore		21. NAME OF CEMETERY Dr. J. H. Moore		22. NAME OF INTERMENT Dr. J. H. Moore		23. NAME OF CREMATION Dr. J. H. Moore		24. NAME OF OTHER DEATH RECORD Dr. J. H. Moore	
25. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		26. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		27. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		28. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		29. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		30. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
31. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		32. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		33. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		34. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		35. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		36. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
37. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		38. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		39. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		40. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		41. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		42. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
43. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		44. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		45. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		46. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		47. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		48. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
49. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		50. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		51. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		52. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		53. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		54. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
55. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		56. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		57. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		58. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		59. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		60. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
61. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		62. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		63. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		64. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		65. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		66. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
67. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		68. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		69. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		70. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		71. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		72. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
73. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		74. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		75. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		76. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		77. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		78. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
79. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		80. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		81. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		82. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		83. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		84. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
85. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		86. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		87. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		88. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		89. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		90. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
91. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		92. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		93. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		94. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		95. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		96. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
97. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		98. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		99. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		100. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		101. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		102. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
103. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		104. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		105. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		106. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		107. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		108. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
109. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		110. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		111. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		112. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		113. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		114. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	
115. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		116. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		117. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		118. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		119. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore		120. NAME OF DECEASED'S NEXT OF KIN Dr. J. H. Moore	



MAKLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18



1  
FOR STATE  
HEALTH DEPT.

is necessary, if any, to be retained for your files. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and in any event within 72 hours after death.

Item 18 F.1m 267-71576045. MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6744 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06711

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1608 Wentworth Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LINDA</b>		First <b>CAROL</b>		Last <b>TROY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>xx</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1959</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter L. Troy</b>				14. MOTHER'S MAIDEN NAME <b>Carolyn M. Bagrosky</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give number or date of service)		17. INFORMANT <b>Mr. Peter L. Troy,</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> 492x Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> 19 <b>p.m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Bradley King, M.D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/13/60</b>	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck 5305 Harford Road #14</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6745

CERTIFICATE OF DEATH

06713  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3615 E. Joppa Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Barbara Veselovsky</u>		4. DATE OF DEATH <u>June 30, 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1889</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Rendes</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>083-18-52768</u>	
17. INFORMANT <u>Ernest Veselovsky</u>		Address <u>Parkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension - arterio sclerosis of the Cardin</u> <u>443X</u> DUE TO (b) <u>Vascular Disorders</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 30, 1945</u> to <u>June 30, 1960</u> , that I last saw the deceased alive on <u>June 30, 1960</u> , and that death occurred at <u>4:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, MD</u> DATE SIGNED <u>7/1/60</u>	
PHYSICIAN'S NAME (Type) <u>J. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 4, 1960</u>	<u>New Freedom Cem.</u>	<u>New Freedom, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JUL 5 '60</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

2745

No. 1000  
Name of Deceased  
Age  
Sex  
Date of Death  
Place of Death  
Cause of Death  
Signature of Physician  
Signature of Registrar  
Date of Registration

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06714

Reg. Dist. No.

6746

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <span style="float: right;">✓</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>26yr11days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;">3801.4</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1823 Riggs Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Vincent</b> Last <b>Vincent</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12, 1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>gys housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas B. Vincent</b>				14. MOTHER'S MAIDEN NAME <b>Helen McGovern</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>903.7 Acute Cardiac failure</b> DUE TO (b) <b>Coronary Vascular Heart Disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Accidental disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>On 5-24-60 pt. found lying on floor, stated she slipped and fell; later complaining of pain in left knee. X-ray showed fracture of left hip</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>1:00 P. M.</b> <b>5-24 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-9-60</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Embrase Inc 1328 Sulphur Spring Rd</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6747

## CERTIFICATE OF DEATH

Reg. Dist. No.

06715

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>		c. LENGTH OF STAY IN 1b <b>6 wks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Foxleigh Convalescent Reisterstown Rd at Valley Rd</b>		d. STREET ADDRESS <b>Belnord Apt 930 Brooks Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Leonard</b> First <b>Wertheimer</b> Last		4. DATE OF DEATH <b>June 8 1960</b> Month <b>June</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1880</b> 79 yrs. 11 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cigar Mfr</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Wertheimer</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Silverstein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>100-11-10000</b>	
17. INFORMANT <b>Mrs. Miriam Wortheimer</b>		Address <b>930 Brooks Lane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Generalized severe arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tuberculosis disease</b> DUE TO (c) <b>Tuberculosis disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>c. 5 d</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 8, 1960</b> , to <b>June 8, 1960</b> , that I last saw the deceased alive on <b>June 8, 1960</b> , and that death occurred at <b>6 p. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Martin</b> M.D.		ADDRESS (Street, city or town, state) <b>1001 St Paul St. Baltimore 2</b>	
PHYSICIAN'S NAME (Type) <b>Louis P. Hamburger Jr.</b>		DATE SIGNED <b>June 8, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-10-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b> ADDRESS <b>1902 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>JUN 14 '60</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Isabel G. Galt		2. SEX Female		3. AGE 60	
4. DATE OF DEATH April 1, 1930		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH New York	
10. OCCUPATION None		11. EDUCATION None		12. RELIGION None	
13. MARITAL STATUS Married		14. DATE OF MARRIAGE 1910		15. NAME OF SPOUSE John G. Galt	
16. NAME OF PHYSICIAN Dr. J. H. Galt		17. NAME OF HOSPITAL None		18. NAME OF NURSE None	
19. NAME OF FUNERAL HOME None		20. NAME OF BURIAL PLACE None		21. NAME OF MINISTER None	
22. NAME OF CORONER None		23. NAME OF JURY None		24. NAME OF JUDGE None	
25. NAME OF COUNTY None		26. NAME OF STATE None		27. NAME OF COUNTRY None	
28. NAME OF DEPARTMENT None		29. NAME OF DIVISION None		30. NAME OF SECTION None	
31. NAME OF OFFICE None		32. NAME OF UNIT None		33. NAME OF STATION None	
34. NAME OF DISTRICT None		35. NAME OF SUB-DISTRICT None		36. NAME OF TERRITORY None	
37. NAME OF PARISH None		38. NAME OF CONGREGATION None		39. NAME OF CHURCH None	
40. NAME OF SYNOD None		41. NAME OF CONFERENCE None		42. NAME OF DISTRICT None	
43. NAME OF ANNUAL CONFERENCE None		44. NAME OF GENERAL CONFERENCE None		45. NAME OF NATIONAL CONFERENCE None	
46. NAME OF INTERNATIONAL CONFERENCE None		47. NAME OF WORLD CONFERENCE None		48. NAME OF UNIVERSAL CONFERENCE None	
49. NAME OF OTHER CONFERENCE None		50. NAME OF OTHER CONFERENCE None		51. NAME OF OTHER CONFERENCE None	
52. NAME OF OTHER CONFERENCE None		53. NAME OF OTHER CONFERENCE None		54. NAME OF OTHER CONFERENCE None	
55. NAME OF OTHER CONFERENCE None		56. NAME OF OTHER CONFERENCE None		57. NAME OF OTHER CONFERENCE None	
58. NAME OF OTHER CONFERENCE None		59. NAME OF OTHER CONFERENCE None		60. NAME OF OTHER CONFERENCE None	
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70. NAME OF OTHER CONFERENCE None		71. NAME OF OTHER CONFERENCE None		72. NAME OF OTHER CONFERENCE None	
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76. NAME OF OTHER CONFERENCE None		77. NAME OF OTHER CONFERENCE None		78. NAME OF OTHER CONFERENCE None	
79. NAME OF OTHER CONFERENCE None		80. NAME OF OTHER CONFERENCE None		81. NAME OF OTHER CONFERENCE None	
82. NAME OF OTHER CONFERENCE None		83. NAME OF OTHER CONFERENCE None		84. NAME OF OTHER CONFERENCE None	
85. NAME OF OTHER CONFERENCE None		86. NAME OF OTHER CONFERENCE None		87. NAME OF OTHER CONFERENCE None	
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91. NAME OF OTHER CONFERENCE None		92. NAME OF OTHER CONFERENCE None		93. NAME OF OTHER CONFERENCE None	
94. NAME OF OTHER CONFERENCE None		95. NAME OF OTHER CONFERENCE None		96. NAME OF OTHER CONFERENCE None	
97. NAME OF OTHER CONFERENCE None		98. NAME OF OTHER CONFERENCE None		99. NAME OF OTHER CONFERENCE None	
100. NAME OF OTHER CONFERENCE None		101. NAME OF OTHER CONFERENCE None		102. NAME OF OTHER CONFERENCE None	

6748

## CERTIFICATE OF DEATH

06716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>				d. STREET ADDRESS <b>Glenarm Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sister Mary Britta Wey</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 7, 1886</b>	
9. AGE (In years last birthday) yrs. <b>75</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Ignatius Wey</b>			
14. MOTHER'S MAIDEN NAME <b>Adelgunda Meyer</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Sister M. Peter Fourier</b> Address <b>Notch Cliff, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Duct cell carcinoma with axillary metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1956</b> to <b>June 1960</b> , that I last saw the deceased alive on <b>June 26, 1960</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>6/29/60</b> ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR TOWSON, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Seiler</b> ADDRESS <b>901 S. COCKLING ST. BALTO., 24, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>NAME OF DECEASED                  [Name of deceased]</p>		<p>DATE OF DEATH                  [Date of death]</p>	
<p>AGE                  [Age of deceased]</p>		<p>SEX                  [Sex of deceased]</p>	
<p>PLACE OF BIRTH                  [Place of birth]</p>		<p>DATE OF BIRTH                  [Date of birth]</p>	
<p>CAUSE OF DEATH                  [Cause of death]</p>		<p>PLACE OF DEATH                  [Place of death]</p>	
<p>DATE OF DEATH                  [Date of death]</p>		<p>TIME OF DEATH                  [Time of death]</p>	
<p>NAME OF DECEASED                  [Name of deceased]</p>		<p>DATE OF DEATH                  [Date of death]</p>	
<p>AGE                  [Age of deceased]</p>		<p>SEX                  [Sex of deceased]</p>	
<p>PLACE OF BIRTH                  [Place of birth]</p>		<p>DATE OF BIRTH                  [Date of birth]</p>	
<p>CAUSE OF DEATH                  [Cause of death]</p>		<p>PLACE OF DEATH                  [Place of death]</p>	
<p>DATE OF DEATH                  [Date of death]</p>		<p>TIME OF DEATH                  [Time of death]</p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6749

CERTIFICATE OF DEATH

Reg. Dist. No.

0671232

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>4mo 4day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>Irene</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/16</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William C. Kinard</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>252-05-7601</u>			
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>				Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/17, 1960</u> to <u>6/21, 1960</u> , that I last saw the deceased alive on <u>6/21, 1960</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D. <u>Mt. Wilson, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>June 22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West View Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Atlanta Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William G. G. Home</u>				ADDRESS <u>4210 Belair Road</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>							

0011 32

DECLASSIFICATION AUTHORITY



1. Wilson, James

2. Wilson, James

3. Wilson, James

4. Wilson, James



5. Wilson, James

6. Wilson, James

7. Wilson, James

8. Wilson, James

9. Wilson, James

10. Wilson, James

11. Wilson, James



6750

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN 1b <b>54</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>56 Hawthorne Rd.</b>		d. STREET ADDRESS <b>56 Hawthorne Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>E.</b> Last <b>WOLF</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1908</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Heinlein</b>		14. MOTHER'S MAIDEN NAME <b>Anna Fischer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-05-3346</b>	
17. INFORMANT <b>William J. Wolf</b>		Address <b>56 Hawthorne Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular apoplexy</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>G I hemorrhage</b> DUE TO (c) <b>metastatic ovarian carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7. weeks</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6/9</b> , 19 <b>58</b> , to <b>6/10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/9</b> , 19 <b>60</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. BLATT</b>		DATE SIGNED <b>434 Eastern Ave.</b>	
PHYSICIAN'S NAME (Type) <b>J. BLATT, M.D.</b>		<b>Essex, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b>		24a. REC'D BY REGISTRAR <b>6224 Eastern Ave.</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Krause</b>		DATE <b>JUN 15 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Form No. 10

DEATH OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

MANNER OF BIRTH

AGE AT BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

6594

## CERTIFICATE OF DEATH

Reg. Dist. No.

06719

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas A</b> Middle <b>Wood</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 8 79</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>5</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mill wright ret</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Wood</b>		14. MOTHER'S MAIDEN NAME <b>Don't know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213 09 0951</b>	
17. INFORMANT <b>Mrs Sabina Wood</b>		Address <b>92 Kinship Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> <b>422.1</b> DUE TO <b>A-s-c-v Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>None</b> (c) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> P. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20</b> , 19 <b>60</b> to <b>June 22</b> , 19 <b>60</b> ; that I last saw the deceased alive on <b>June 22</b> , 19 <b>60</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>6800 Morningside Road</b> DATE SIGNED <b>6/22/60</b>	
ACTUAL SIGNATURE <b>M.B. Davis</b>		PHYSICIAN'S NAME (Type) <b>M.B. DAVIS MD. Dundalk - 22 Ind</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>June 25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Belair Mem Gardens</b>	
22d. LOCATION (City, town, or county) (State) <b>Belair Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '60</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinsaid</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

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M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
06720									
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY	
Baltimore		Baltimore-7		63 Yrs.		Maryland		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7319 Elmore Rd.						7319 Elmore Rd.			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
Bertha		Gertrude		Wunder		June		7 19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) Months Days Hours Min.	
Female		White				Feb. 11, 1889		71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Employed at C.R. Daniels, Inc.								Balto. City, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
Henry S. Baker				Elizabeth L. Nicholson				U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
no				213-05-0213		Mrs. Eliz. Bees, 138 McPhail St., Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Pulmonary Oedema Conditions, if any, which gave rise to immediate cause (b) Cardiac Decompensation (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none								INTERVAL BETWEEN ONSET AND DEATH 1 hr. est. 2 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
none				none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
none 19				none		none		none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED	
D. D. Caples				M.D.				6-8-60	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER					
D. D. Caples, M. D.				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial		6-10-60		Mt. Olive		Randallstown, Balto., Md.			
23. FUNERAL DIRECTOR ADDRESS						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
G. Howard Strong, 3207 W. North Ave., Balto.						JUN 13 '60		Arthur L. Kraus	

FOR MAIL  
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RECEIVED BY THE  
DIRECTOR OF THE  
BUREAU OF THE  
INTERNAL SECURITY  
DIVISION  
JAN 10 1950  
U.S. DEPT. OF JUSTICE  
WASHINGTON, D.C.

TO THE DIRECTOR  
FROM THE  
SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06721

Reg. Dist. No.

6752

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curlio Bay</u>		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u>				d. STREET ADDRESS <u>1615 Halbert St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KARALINA</u> <u>ZUKAITIS</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>2</u> <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-15-1889</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca of the liver</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6.2.1960</u> to <u>6.2.1960</u> , that I last saw the deceased alive on <u>6.2.1960</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stanley Ankudars</u> M.D.				ADDRESS (Street, city or town, state) <u>1802 N. Becht Blvd.</u>		DATE SIGNED <u>Becht 23 MD</u>	
PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDARS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ludon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Sachanash</u>				ADDRESS <u>637 West Blvd</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 1960</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G267 7-14-60 et

06722

6753

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fork</i>		c. LENGTH OF STAY IN 1b <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stoney Batter Road</i>		d. STREET ADDRESS <i>Stoney Batter Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Ann Zuluf</i>		4. DATE OF DEATH Month Day Year <i>June 25 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 21 1889</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <i>70</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Co., Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Franz A. Walther</i>		14. MOTHER'S MAIDEN NAME <i>Anna Lee Barker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(Yes, no, or unknown)</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mr. Benjamin F. Zuluf</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Diabetes</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>4 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1960</i> to <i>June 25, 1960</i> , that I last saw the deceased alive on <i>June 25, 1960</i> , and that death occurred at <i>4:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William A. Tyson</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Kingville, Md. 6-25-60</i>	
PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/28/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fork Methodist Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

